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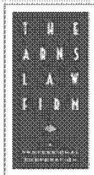
ELECTRONICALLY
FILED
Superior Court of California, County of San Francisco
08/17/2015
Clerk of the Court
BY:WILLIAM TRUPEK
Deputy Clerk

IN THE SUPERIOR COURT OF THE STATE OF CALIFORNIA
IN AND FOR THE COUNTY OF SAN FRANCISCO
CIVIL UNLIMITED

COORDINATION PROCEEDING SPECIAL TITLE [RULE 3.550] **BLUE SHIELD OF CALIFORNIA AFFORDABLE CARE ACT CASES** JOHN HARRINGTON, BARRY WEISS, JON DAUM, KEVIN AND JANE MCCARTHY, AND LORI SCARPO, Individually and On Behalf of All Others Similarly Situated, Plaintiffs,	Judicial Council Coordination Proceeding No.: 4800 S.F. Super. Ct. Case No.: CGC-14-539283 L.A. Super. Ct. Case No.: BC550977 San Diego Super. Ct. Case No.: 37-2014-0023350-CU-MT-CTL L.A. Super. Ct. Case No.: BC558549 S.F. Super. Ct. Case No.: CGC-14-543281 **CONSOLIDATED CLASS ACTION COMPLAINT FOR DAMAGES [C.C.P. § 382] WITH EXHIBITS AND DEMAND FOR JURY TRIAL**



vs.

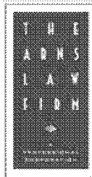
CALIFORNIA PHYSICIANS' SERVICE, d/b/a BLUE SHIELD OF CALIFORNIA and DOES 1 to 100, inclusive,

Defendants.

1. Violation of the CLRA (Civ. Code, §§ 1750, *et seq.*)
2. Violation of the UCL (Bus. & Prof. Code, §§ 17200, *et seq.*) – Unlawful Business Acts and Practices
3. Violation of the UCL (Bus. & Prof. Code, §§ 17200, *et seq.*) – Unfair Business Acts and Practices
4. Violation of the UCL (Bus. & Prof. Code, §§ 17200, *et seq.*) – Fraudulent Business Acts and Practices
5. Violation of the False Advertising Law (Bus. & Prof. Code, §§ 17500, *et seq.*)
6. Breach of Contract
7. Breach of the Implied Covenant of Good Faith and Fair Dealing
8. Declaratory Relief

AMOUNT EXCEEDS $10,000

Judge: Hon. Mary E. Wiss
Dept: 305



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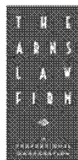

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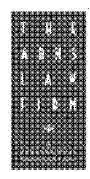


Plaintiffs, JOHN HARRINGTON, ALEX TALON, DANIEL SULLIVAN, KIERAN TURNER, JON DAUM, STEVEN YERKES, ERIN HARVEY, KEVIN AND JANE MCCARTHY, SALLY GREER, TIEMO MEHNER, CYNTHIA CARLSON, BARRY WEISS, LORI SCARPO, and SHEILAH ASHER, on behalf of themselves and all others similarly situated (collectively, "Plaintiffs"), bring this action against Defendants California Physicians' Service dba Blue Shield of California ("Blue Shield" or "Defendant") and Does 1 through 100. Plaintiffs allege the following on information and belief, except as to those allegations that pertain to the named Plaintiffs, which are alleged on personal knowledge:

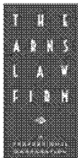
NATURE OF THE ACTION

1. Plaintiffs in this coordinated action challenge Blue Shield's deceptive "bait and switch" misrepresentations, inadequate physician and hospital networks, and grossly mishandled administration of individual health service plans.[1] In violation of California law, Blue Shield:

- Misrepresented to consumers that their physicians and hospitals ("providers") participate in Blue Shield health service plans;
- Made false and misleading representations and omissions about provider networks in its advertising, marketing, and other communications, including representations and omissions about Blue Shield's 2014 and 2015 health service plans, which allowed members to obtain medical services from far fewer providers than previous, similar Blue Shield plans; and,
- Prevented Class members from obtaining medical services for months by failing to provide them with identification cards or proof of enrollment, even while the Class members continued to pay for their health plans.

2. Blue Shield is one of California's largest health care service plan corporations. Blue Shield's business involves paying part of the cost of its members' health care services and performing a variety of services on their behalf. For example, Blue Shield establishes networks of health care providers (including doctors, nurses, hospitals, and pharmacies) that agree to provide medical products and services at negotiated rates. Blue Shield also provides claims-processing services, serves as a single point of contact for billing issues, and ensures that its

[1] The term "individual health service plans" refers to plans that cover single "individuals" as well as family plans. The term is used to distinguish the individual and family plans from group plans, such as those offered through an employer.



providers are performing appropriate medical treatments at the negotiated rates.

3. Blue Shield and other health care service plans commonly administer multiple health service plans. The terms, conditions, and benefits of each health plan are memorialized in standard contracts between the health care service plan and the health plan members, known as "Evidence of Coverage," or "EOC."

4. Depending on the terms of their plan, the members make monthly payments to Blue Shield and also pay part of their health care costs, either through a co-payment, which is a fixed dollar amount for a given service, or by paying a percentage of the cost of the service.[2]

5. Blue Shield's health service plans include Preferred Provider Organization ("PPO") and Exclusive Provider Organization ("EPO") plans. Both PPO and EPO plans allow members to obtain care from in-network providers at a reduced cost.[3] PPO plans also provide some coverage for care received from out-of-network providers, but it is much more expensive for a PPO plan member to see an out-of-network provider. PPO plan members who visit out-of-network providers do not enjoy the benefit of the negotiated fee schedules and are therefore faced with the full billed amount of the service, which is often twice as much as the allowed amount or more. EPO plans do not cover out-of-network, non-emergency services to any extent.

6. In late 2013, to comply with the Patient Protection and Affordable Care Act of 2010, Public Law 111-148, 124 Stat. 119 (2010) ("ACA"), Blue Shield announced that it would cancel its existing individual health service plans effective January 1, 2014, and offer new individual plans that complied with ACA requirements.

7. Blue Shield offered its new ACA-compliant plans to consumers during two designated enrollment periods: between October 1, 2013 and March 31, 2014 ("2014 Open Enrollment Period"), and between November 15, 2014 and February 15, 2015 ("2015 Open Enrollment Period") (collectively, "Open Enrollment Periods").

8. Compared with its pre-ACA plans, Blue Shield's 2014 and 2015 ACA-compliant plans provided access to significantly smaller, narrower provider networks. These new networks, which Blue Shield referred to as the "*Exclusive* [PPO and EPO] Networks," include

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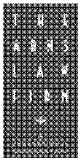
[2] For those plans with annual deductibles, this cost-sharing structure is subject to members first meeting that plan's annual deductible (if applicable).

[3] The reduced cost is the result of pre-negotiated fee schedules entered into between Blue Shield and network providers and is also known as the "allowed amount."



just a fraction of the providers in the Blue Shield PPO provider network that previously supported its individual plans, and that continues to support most of its group plans.

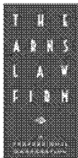
9. Despite this, Blue Shield represented and marketed its health service plans as having a robust and extensive network of providers throughout California. Blue Shield misrepresented the extent of its provider networks and concealed and failed to disclose the significant differences between the narrow provider network available under the new ACA-compliant health service plans and the traditional, large Blue Shield of California PPO provider network. Blue Shield also misrepresented that specific providers were available under the ACA-compliant health service plans, when they were not.

10. In reliance on Blue Shield's representations and omissions regarding provider networks, Plaintiffs and Class members enrolled in Blue Shield's health service plans.

11. After they enrolled in the new Blue Shield plans, some members attempted to receive services under their plans only to find out that their provider networks did not include the providers Blue Shield had represented as in-network. Others never received services, in some cases because they were unable to locate a provider included in the new narrow network. By limiting in-network benefits to so few providers, Blue Shield deprived these members of promised benefits. Due to Blue Shield's actions and misrepresentations, Plaintiffs and Class members have been denied the full benefits of the plans they purchased. Specifically:

- Promised providers were not in-network;
- Negotiated fee schedules were not available;
- A reduced percentage of the providers' charges was paid by Blue Shield;
- Payments made to out-of-network providers did not accrue toward Plaintiffs' and Class members' annual deductibles; and
- Payments made to out-of-network providers did not accrue toward Plaintiffs' and Class members' annual out-of-pocket limits.

12. Blue Shield concealed its narrowed networks in order to increase sales of its health service plans. Some Plaintiffs and Class members did not find out about the narrowed networks until after the Open Enrollment Periods ended. As a result, they were locked into the misrepresented plans until the next Open Enrollment Period. Other Plaintiffs and Class members did not find out about the narrowed networks until they either were turned away by their provider



or they received care, only to be surprised when Blue Shield refused to pay its share of the cost. Some Class members may still be unaware of the true nature of the narrow network.

13. Blue Shield had a clear incentive to conceal its narrow networks. As a result of these practices, Blue Shield significantly increased its share of the California individual health service plan market, while offering inferior products and shifting its share of medical costs onto its plan members.

14. Additionally, many consumers who enrolled in Blue Shield's plans did not receive their health plan enrollment cards ("ID cards") for up to three months, which prevented them from obtaining medical care or forced them to pay out-of-pocket when they did.

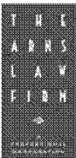
15. By selling health service plans that fail to provide advertised benefits, including access to physicians and hospitals, and by not delivering ID cards for months, Blue Shield's deceptive business practices damaged Plaintiffs and Class members. In addition to the monetary losses, Plaintiffs and Class members who called Blue Shield's customer service telephone line had to wait on hold for two to three hours before navigating a labyrinth of automated phone trees, being repeatedly transferred among different representatives, and frequently were disconnected and forced to start over again.

16. Plaintiffs bring this action on behalf of themselves and on behalf of classes of current California residents who are or were enrolled in a Blue Shield individual health service plan contract purchased on or after October 1, 2013.

17. Blue Shield's misrepresentations and omissions regarding the extent and timing of benefits and provider networks fraudulently induced Plaintiffs into purchasing a health service plan.

18. Blue Shield's unlawful, unfair, and fraudulent conduct violates California Business and Professions Code sections 17200, *et seq.* and 17500, *et seq.*

19. Blue Shield employed bait and switch tactics of representing and advertising that its health service plans provided in-network access to a robust and extensive network of providers throughout California. Blue Shield misrepresented the extent of its provider networks, along with the concealment and failure to disclose the existence of substantial differences between the narrow Blue Shield provider networks (that were available to members through the newly issued ACA-compliant health service plans) and the traditional, more extensive Blue



Shield of California PPO provider network. Blue Shield also misrepresented that certain providers were in the plans' networks when those providers were not actually in the plans' networks. Each of these violate the Consumers Legal Remedies Act (hereafter, "CLRA"), California Civil Code section 1750, *et seq*.

20. Finally, through its conduct of misrepresenting its plans' provider networks and failing to provide proof of healthcare coverage to consumers, Blue Shield has breached the individual health service plan contracts entered into with Plaintiffs and Class members and breached the implied covenant of good faith and fair dealing.

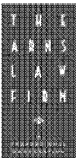
21. Plaintiffs seek to recover damages caused by Blue Shield's intentional misrepresentation and concealment of material facts about Blue Shield's new ACA-compliant health service plans during the Open Enrollment Periods; damages resulting from Blue Shield's breach of contract and breach of the implied covenant of good faith and fair dealing; an order of this Court enjoining Blue Shield's continued unlawful, unfair, and fraudulent conduct; an order for restitution of all monies paid for Blue Shield health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the advertised networks of providers and the value of the health service plans as delivered by Blue Shield, and (ii) premium payments made by consumers for the period during which consumers were not provided ID cards; and other remedies as set forth herein.

JURISDICTION AND VENUE

22. This class action is brought pursuant to section 382 of the California Code of Civil Procedure and section 1781 of the Civil Code and seeks to remedy Blue Shield's violations of state law, including the Civil Code, Business and Professions Code, and California common law arising from and related to Blue Shield's misrepresentations regarding its individual and family health service plans and services, as well as related misconduct.

23. The Superior Court has jurisdiction over this action. Blue Shield is conducting unlawful, unfair and deceptive business practices in the County of San Francisco.

24. Venue is proper in this Court because, inter alia, Blue Shield's place of residence is in the County of San Francisco and Blue Shield engages and performs business activities in the County of San Francisco. Plaintiffs Harrington and Talon entered into agreements to purchase Blue Shield's health service plans and services while in the County of San Francisco.



Additionally, the Judicial Council of California formally coordinated the actions that comprise this coordinated proceeding and assigned the action to this Court on November 21, 2014.

PARTIES

25. Plaintiff John Harrington (Harrington) is, and at all times relevant herein was, a resident of the City and County of San Francisco, California. Harrington purchased an individual PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

26. Plaintiff Alex Talon (Talon) is, and at all times relevant herein was, a resident of the City and County of San Francisco, California. Talon purchased an individual PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

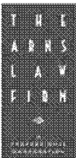
27. Plaintiff Daniel Sullivan (Sullivan) is, and at all times relevant herein was, a resident of the City and County of Los Angeles, California. Sullivan purchased a family PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

28. Plaintiff Kieran Turner (Turner) is, and at all times relevant herein was, a resident of the City and County of Los Angeles, California. Turner purchased an individual PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

29. Plaintiff Jon Daum (Daum) is, and at all times relevant herein was, a resident of the City and County of San Diego, California. Daum purchased a family PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

30. Plaintiff Steven Yerkes (Yerkes) is, and at all times relevant herein was, a resident of the City and County of San Diego, California. Yerkes purchased a family PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

31. Plaintiff Erin Harvey (Harvey) is, and at all times relevant herein was, a resident of the City and County of San Diego, California. Harvey purchased an individual PPO health



service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

32. Plaintiffs Kevin and Jane McCarthy (McCarthys) are, and at all times relevant herein were, residents of the County of Ventura, California. The McCarthys purchased a family PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

33. Plaintiff Sally Greer (Greer) is, and at all times relevant herein was, a resident of the County of Orange, California. Greer purchased an individual PPO health care plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

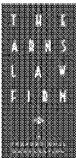
34. Plaintiffs Tiemo Mehner (Mehner) and Cynthia Carlson (Carlson) are, and at all times relevant herein were, residents of the County of Los Angeles, California. Mehner and Carlson purchased a family PPO health service plan from Blue Shield based on the coverage afforded under this plan.

35. Plaintiff Barry Weiss (Weiss) is, and at all times relevant herein was, a resident of the City and County of Los Angeles, California. Weiss purchased an individual PPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

36. Plaintiff Lori Scarpo (Scarpo) is, and at all times relevant herein was, a resident of the City of Redondo Beach, California. Scarpo purchased an individual PPO health service plan from Defendants based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

37. Plaintiff Sheilah Asher (Asher) is, and at all times relevant herein was, a resident of the County of Amador. Asher purchased an individual EPO health service plan from Blue Shield based on misrepresentations and omissions made regarding the coverage afforded and provider networks available under this plan.

38. Defendant California Physicians' Service dba Blue Shield of California is a corporation duly organized and existing under the laws of the State of California, with its principal place of business located at 50 Beale Street in San Francisco, California. Blue Shield maintains substantial ongoing business operations throughout California, including in the County



of San Francisco. It is authorized to conduct business as a health care service plan and transacts, and is transacting, the business of providing health service plans to consumers throughout this State.

39. The true names and capacities of DOES 1 through 100, inclusive, are unknown to Plaintiffs who sue such Defendants by use of such fictitious names. Plaintiffs will amend this complaint to add the true names when they are ascertained. Plaintiffs are informed and believe and thereon allege that each of the fictitiously named Defendants is legally responsible for the occurrences herein alleged, and that Plaintiffs' damages as herein alleged were proximately caused by their conduct.

CLASS ACTION ALLEGATIONS

A. The Classes

40. Plaintiffs bring this action as a class action pursuant to Code of Civil Procedure section 382 and Civil Code section 1781, on behalf of themselves and the following Classes (collectively referred to as the "Class"):

1. Restitution Class, on behalf of all Plaintiffs:

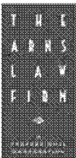
   All current California residents who on or after October 1, 2013 enrolled in any Blue Shield individual or family health service plan that has a network with fewer physicians and hospitals than the full Blue Shield of California PPO network.

2. PPO Out-of-Pocket Class, on behalf of Plaintiffs Harrington, Talon, Sullivan, Turner, Daum, Yerkes, Harvey, the McCarthys, Greer, Weiss, and Scarpo:

   All current California residents who on or after October 1, 2013 enrolled in any Blue Shield individual or family PPO health service plan and who were charged out-of-network rates for services or treatments rendered by physicians or facilities that were in the full Blue Shield of California PPO network at any time in the year of treatment.

3. EPO Out-of-Pocket Class, on behalf of Plaintiff Asher:

   All current California residents who on or after October 1, 2013 enrolled in any Blue Shield individual or family EPO health service plan and who were charged out-of-network rates for services or treatments rendered by physicians or facilities that were in the full Blue Shield of California PPO network at any time in the year of treatment.



4. Rollover Class, on behalf of Plaintiffs Sullivan, Turner, and Asher:

> All Class members who were enrolled in a Blue Shield individual or family health service plan issued sometime after March 23, 2010 that was cancelled or not renewed as of December 31, 2013 and who enrolled in an individual or family Blue Shield PPO or EPO plan effective January 1, 2014.

5. Delayed Enrollment Class, on behalf of Plaintiffs Harrington, Mehner, and Carlson:

> All Class members who were not provided proof of their health service plan coverage (i.e., member identification card) within 10 days of remitting initial payment for their plans or January 1, 2014, whichever is later.

41. Plaintiffs reserve the right to amend these definitions if discovery and/or further investigation demonstrates that the Classes should be expanded or otherwise modified.

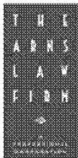
42. Excluded from the Class are Blue Shield's employees, officers, directors, legal representatives, successors, and assigns, any entity in which Blue Shield has a controlling interest, any Judge to whom the litigation is assigned and all members of her or her immediate family, and all persons who timely and validly request exclusion from the Class.

43. The members of the Class are so numerous that joinder of all members would be impracticable. The precise number of Class members and their identities and addresses are unknown to Plaintiffs at this time, but such number, and the identity and address of each Class member, can be readily ascertained from Defendants' records. Class members may be notified of the pendency of this action by mail, supplemented (if deemed necessary or appropriate by the Court) by published notice.

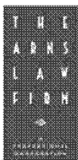
44. There is a well-defined community of interest in common questions of law and fact that exists as to all members of the Class. These questions predominate over the questions affecting only individual Class members. These common legal and factual questions include:

i. Whether Blue Shield misrepresented, concealed, or failed to disclose to Plaintiffs the terms of Plaintiffs' health service plans;

ii. Whether Blue Shield's misrepresentations, concealments, or failures to disclose the terms of Plaintiffs' health service plans were negligent in nature, in violation of



1 California law;
2 iii. Whether Blue Shield failed to communicate to Plaintiffs, in good faith, facts or
3 material terms of the health service plans Plaintiffs purchased;
4 iv. Whether Blue Shield falsely advertised the health service plans Plaintiffs purchased;
5 v. Whether Blue Shield's provider lists for its ACA individual and family plans were
6 inaccurate;
7 vi. Whether inaccuracies in Blue Shield's provider lists misled Class members;
8 vii. Whether Blue Shield breached its contracts and the implied covenants of good faith
9 and fair dealing with Plaintiffs and Class members by providing prospective and
10 current members with inaccurate provider lists;
11 viii. Whether Blue Shield's conduct constitutes fraudulent, unlawful, or unfair business
12 practices in violation of Business and Professions Code section 17200, *et seq.*;
13 ix. Whether Blue Shield's conduct otherwise violates California law;
14 x. Whether Blue Shield's wrongful conduct damaged Plaintiffs and Class Members; and
15 xi. Whether, as a result of Blue Shield's conduct, Plaintiffs are entitled to damages,
16 restitution, equitable relief and/or other damages and relief, and, if so, the amount and
17 nature of such relief.
18 45. Plaintiffs bring claims that are typical of the claims of the members of the Class.
19 Plaintiffs' and Class members' claims arise from a common course of conduct by Blue Shield and
20 are based on the same legal theories. Plaintiffs have no interests antagonistic to those of the Class
21 and are not subject to any unique defenses.
22 46. Plaintiffs Harrington, Talon, Sullivan, Turner, Daum, Yerkes, Harvey, the
23 McCarthys, Greer, Mehner, Carlson, Weiss, Scarpo, and Asher are adequate representatives of
24 the Class because their interests do no conflict with the interests of the Class, and they have
25 retained counsel competent and experienced in complex class action litigation. The interests of
26 the Class will be fairly and adequately protected by Plaintiffs and their counsel.
27 47. A class action is superior to all other available methods for the fair and efficient
28



adjudication of this controversy for, inter alia, the following reasons:

i. It is economically impractical for members of the Class to prosecute individual actions. The damages suffered by Class members are likely to exceed millions of dollars. However, while the damages suffered by each individual Class member are significant, they are small in comparison to the burden and expense of individual prosecution. Without the class action device, it would be virtually impossible for Class members individually to obtain effective redress for the wrongs done to them.

ii. Furthermore, even if the Class members themselves could afford such individual litigation of their claims, the court system could not. Individualized litigation presents a potential for inconsistent or contradictory judgments. Individualized litigation would involve thousands of separate actions, increasing the delay and expense to all parties and to the court system. By contrast, the class action device presents fewer management difficulties, requiring only a single adjudication of the complex legal and factual issues in this dispute, thereby providing the benefits of economy of scale, and comprehensive supervision by a single court.

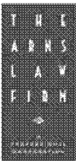
iii. Finally, the Class is readily definable.

48. Plaintiffs and their counsel know of no difficulties which will be encountered in the management of this case which would preclude it being maintained as a class action.

STATUTORY AND REGULATORY SCHEME

49. On March 23, 2010, President Obama signed into law the ACA. The ACA included a requirement known as the "individual mandate" obliging individuals to obtain health coverage with a "minimum essential" level of benefits. (26 U.S.C. § 5000A.) Under the individual mandate, individuals who were not exempt or were not covered under a health care plan through a third party, such as their employers, satisfied the requirement by purchasing an individual ACA-compliant health plan from a private company.

50. Under the ACA, states are permitted to create state-run health care service plan exchanges known as "marketplaces." In these marketplaces, individuals are given options of



healthcare coverage from a number of private companies offering a variety of different plans.

51. California was the first state to establish a marketplace with the passage of the California Patient Protection and Affordable Care Act of 2010, Assem. Bill No. 1602 and Sen. Bill No. 900 (2010) ("CPPACA"). The marketplace is known as "Covered California" and is administered by a public agency called the California Health Benefit Exchange or simply "Covered California."

52. Individuals could purchase health service plans through Covered California during the initial 2014 Open Enrollment Period and later during the 2015 Open Enrollment Period (45 C.F.R. § 155.410.) Individuals could also purchase health service plans directly from companies like Blue Shield during the Open Enrollment Periods.

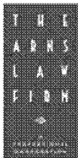
53. Californians who did not enroll in Covered California and who remained uninsured after the end of the Open Enrollment Periods were subject to a penalty of the higher of either 1% of their yearly household income or $95. This penalty increased in 2015 to the higher of either 2% of yearly household income or $325.

54. The ACA does <u>not</u> displace state laws that impose stricter requirements on health care service plans than those imposed by the ACA, and it expressly preserves state laws that offer additional consumer protections that do not "prevent the application" of any ACA requirement. (42 U.S.C. § 18041(d).)

55. Blue Shield is a health care service plan governed by California Health and Safety Code sections 1340 through 1399.99, also known as the "Knox-Keene Health Care Service Plan Act of 1975" ("Knox-Keene Act"). The Knox-Keene Act is a comprehensive system of laws governing all aspects of health care service plans, including financial stability, organization, advertising, and capability to provide health care services.

56. In adopting the Knox-Keene Act, it was the "intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California" by:

i. "Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace."



(Health & Saf. Code, § 1342(b));

ii. "Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public." (*Id.* at (c)); and

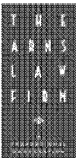
iii. "Helping to ensure the best possible health care for the public at the lowest possible cost by transferring the financial risk of health care from patients to providers." (*Id.* at (d).)

57. Health and Safety Code section 1367, subdivision (h)(1), provides that "contracts with subscribers and enrollees . . . shall be fair, reasonable, and consistent with the objectives of [the Knox-Keene Act]."

58. To further the goals of ensuring that consumers are educated and informed about the coverage and benefits and enabling consumer choice in the marketplace, the Knox-Keene Act prohibits Blue Shield and other health care service plans from using "any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive." (Health & Saf. Code § 1360(a).) Additionally, under this statute, no health care service plan "shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact." (*Id.* at (b).) For purposes of the statute:

i. "A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee." (*Id.* at (a)(1).)

ii. "A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or



1 potential enrollee or subscriber, in a plan, and such is not the case." (*Id.* at (a)(2).)

2 59. Health and Safety Code section 1360 also prohibits the use of any evidence of
3 coverage that is deceptive, which is defined as one that "taken as a whole and with consideration
4 given to typography and format, as well as language, shall be such as to cause a reasonable
5 person, not possessing special knowledge of plans, and evidence of coverage therefor to expect
6 benefits, service charges, or other advantages which the evidence of coverage does not provide or
7 which the plan issuing such coverage or evidence of coverage does not regularly make available
8 to enrollees." (*Id.* at (a)(3).)

9 60. The Knox-Keene Act also requires a health care service plan to "provide, upon
10 request, a list of … contracting providers, within the enrollee's or prospective enrollee's general
11 geographic area" including a list of "[p]rimary care providers." (Health & Saf. Code §
12 1367.26(a)(1).) "A health care service plan shall provide this information in written form to its
13 enrollees or prospective enrollees upon request. A plan may, with the permission of the enrollee,
14 satisfy the requirements of this section by directing the enrollee or prospective enrollee to the
15 plan's provider listings on its Internet Web site . . . ." (*Id.* at (d).)

16 61. Additionally, the Knox-Keene Act requires regulators to "develop and adopt
17 regulations to ensure that enrollees have access to needed health care services in a timely
18 manner." (Health & Saf. Code § 1367.03(a).) Under these regulations (Title 28 of the California
19 Code of Regulations ["28 CCR"] § 1300.67.2, *et seq.*):

20 i. "Plans shall provide or arrange for the provision of covered health care services in a
21 timely manner appropriate for the nature of the enrollee's condition consistent with
22 good professional practice. Plans shall establish and maintain provider networks,
23 policies, procedures and quality assurance monitoring systems and processes
24 sufficient to ensure compliance with this clinical appropriateness standard." (28 CCR
25 § 1300.67.2.2(c)(1).)

26 ii. "[E]ach plan shall ensure that its contracted provider network has adequate capacity
27 and availability of licensed health care providers to offer enrollees appointments that
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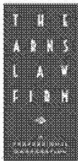


meet [certain] timeframes[.]" (28 CCR § 1300.67.2.2(c)(5).) For example, a contracted provider network must be able to offer members "[n]on-urgent appointments for primary care within ten business days of the request for appointment[.]" (*Id.* at (c)(5)(C).)

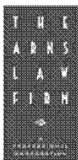
iii. "Plans shall ensure they have sufficient numbers of contracted providers to maintain compliance with the standards established by [28 CCR § 1300.67.2.2(c)]." (28 CCR § 1300.67.2.2(c)(7).)

iv. Plans must ensure that primary health care service facilities are available to members "within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility." (28 CCR. § 1300.67.2(a); see 28 CCR § 1300.67.2.1; 20 CCR § 1300.51(c)(H).) For example, health care service plans must ensure that "[a]ll enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated primary care provider in such numbers and distribution as to accord to all enrollees a ratio of at least one primary care provider (on a full-time equivalent basis) to each 2,000 enrollees." (20 CCR § 1300.51(c)(H)(i).)

v. "Plans shall ensure that, during normal business hours, the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes." (28 CCR § 1300.67.2.2(c)(10).)

62. "Contracts between health care service plans and health care providers shall assure compliance with the standards" set forth in 28 CCR § 1300.67.2 *et seq.*, quoted above. (Health & Saf. Code § 1367.03(f)(1).) "These contracts shall require reporting by health care providers to health care service plans and by health care service plans to [regulators] to ensure compliance with the[se] standards." (*Ibid.*)

63. To further the goals of ensuring the best possible health care for the public at the lowest possible cost, the Knox-Keene Act provides that a health care service plan, at the request



of an enrollee, must arrange the completion of covered services by a terminated provider or by a nonparticipating provider for an acute condition, serious chronic condition, pregnancies, terminal illness, care of a newborn child, or performance of surgery. (Health & Saf. Code § 1373.96(a)-(c), (l), (m)(2).) "A health care service plan … shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." (Health & Saf. Code § 1367(d).)

FACTUAL ALLEGATIONS

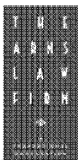
A. Blue Shield Engaged in a Fraudulent and Deceptive Marketing Scheme to Increase Its Market Share.

64. In late 2013, to coincide with the commencement of the ACA, Blue Shield began offering California consumers new ACA-compliant individual and family health service plans effective January 1, 2014.

65. Blue Shield offered its new individual ACA-compliant PPO and EPO plans inside and outside the Covered California exchange during the 2014 and 2015 Open Enrollment Periods.

66. The networks of providers available to Plaintiffs and Class members under their ACA-compliant Blue Shield PPO and EPO plans were drastically more limited than the networks of providers available under Blue Shield individual plans prior to the ACA and Blue Shield employer-sponsored plans. As of June 2014 Blue Shield's network for its ACA-compliant individual and family plans had just 64% of the physicians that are covered in-network for its employer-sponsored plans.

67. However, in an effort to increase its share of the California individual health service plan market, Blue Shield fraudulently and deceptively marketed these plans. Blue Shield omitted the existence and nature of its "narrow network" of providers while at the same time touting the applicable provider network as robust and implying it was the same network available under Blue Shield's group plans and previous individual plans. Compounding the problem was



the fact that Blue Shield listed providers as "in-network" when they were not.

B. Blue Shield Misrepresented and Failed to Disclose to Its Members That Its 2014 Provider Networks Were Significantly More Limited Than Its Previous Networks.

68. In the fall of 2013, Blue Shield began taking steps to cancel all of its then-existing non-grandfathered[4] individual health service plans in order to comply with California's December 31, 2013 deadline for ACA compliance.[5]

69. Blue Shield sent letters to members of such plans notifying them that, as of December 31, 2013, their current health service plan no longer would be in effect. The letter stated that, beginning January 1, 2014, Blue Shield would be offering "new quality health plans" with "expanded levels of coverage." The letter provided a "recommended new plan option" that Blue Shield stated was a "good fit" for the members based on the benefits and coverage levels of their current plans. Blue Shield instructed the members to simply continue paying their monthly premiums at the new rate in order to "continue your Blue Shield coverage in 2014" under the recommended new plan. Blue Shield's representations in the letters were uniform among individual PPO members.

70. No mention is made in the letter that the new health plans would provide a significantly smaller provider network or that there was a high likelihood that the members' established providers would be out of network.

71. If members took no action and continued to pay their monthly premiums, they would automatically be enrolled in Blue Shield's recommended plan.

72. A Blue Shield brochure accompanied the letter, describing and marketing the new ACA-compliant plans.

73. No mention is made in the brochure that the new health plans would provide a significantly smaller provider network or that there was a high likelihood that the members' established doctors would be out of network. Rather, it indicated that there was one provider

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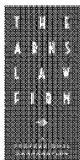
[4] "Grandfathered plans" are those plans that were purchased prior to March 23, 2014 and were not required to meet certain ACA-mandated changes. No Class members are or were enrolled in grandfathered plans.

[5] Covered California elected to keep the original deadline of December 31, 2013 for compliance with the ACA by individual plans despite the federal government's extension to December 31, 2014.



network that is the same for *all* Blue Shield plans. For example, the brochure refers to "our PPO network," "our network," and "Blue Shield's network" numerous times. It also states: "Blue Shield's PPO plans provide access to a quality network of doctors, specialists, and hospitals. Members have the freedom to see *any doctor in our PPO network* without a referral." It further represents that members will continue to enjoy the same benefits of their then-existing plans: "You've come to expect the best from Blue Shield, and that isn't going to change."

74. Blue Shield's representations, concealments, and/or failures to disclose, indicated to current members that they would continue to have access to the same network of providers, continue to be able to see their current doctors under the new recommended plan, and that their coverage would continue as normal.

75. Contrary to Blue Shield's representations, concealments, and/or failures to disclose, members who continued with Blue Shield after their 2013 plans were cancelled had available to them only a very narrow network of providers that was substantially different from and lesser than the traditional "large, high-quality" Blue Shield PPO provider network that, prior to January 1, 2014, backed all Blue Shield PPO plans.

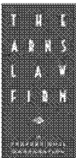
76. At all relevant times, Blue Shield had or should have had full knowledge of the extent of its narrow network as well as the identities of those providers participating in it.

C. Blue Shield Misrepresented and Omitted in Its Sales and Marketing Materials the Fact That Its Provider Networks Were Significantly More Limited Than Its Previous Networks.

77. Blue Shield's representations, concealments, and/or failures to disclose, on Blue Shield's website and in its television advertisements and marketing materials as well as on the Covered California website and in other media, indicated that a singular and expansive Blue Shield provider network would be available to members of Blue Shield healthcare service plans.

78. Blue Shield's marketing materials indicated that the only changes Blue Shield made to its older individual health service plans were changes to ensure compliance with ACA requirements.

79. At all relevant times, Blue Shield compared and continues to compare its plans in two tables available on the Blue Shield website, an "html" version and a "pdf" version. The tables in either format provide information regarding the prices of specific medical services and doctor office visits, prescription benefits, calendar-year medical deductibles, calendar-year out-



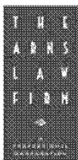
of-pocket maximums (including deductibles), and calendar-year brand drug deductibles. Neither the html nor the pdf table indicates in any way that the various plans offer access to a unique network of providers that is different than or merely a subset of the network offered under Blue Shield's other plans.

80. Similarly, the Covered California website has at all relevant times compared and continues to compare the Blue Shield plans it offers in html format on its website. The comparison of the plans provides information regarding the cost of the plan on a monthly basis, deductible amounts, copays, prescription benefits, and maximum out-of-pocket expenses. The comparison does not indicate in any way that the various plans offer access to a unique network of providers that is different than or merely a subset of the network offered under Blue Shield's other plans.

81. At all relevant times, the Blue Shield website has offered and continues to offer users a "find a provider" feature that allows members, potential members, and Blue Shield-contracted providers to search for providers available under its various plans. From the fall of 2013 through approximately August 2014 (well through the 2014 Open Enrollment Period), when users selected this feature, they were given options to log in to their Blue Shield account—if they are already existing members with member identification numbers—or, select a plan to view the providers available under one of 35 different plans, or answer a query "what are you looking for?" by indicating they are looking for a "doctor." When users selected a plan or indicated they were looking for a doctor, they were given the option to select physicians listed on the "Blue Shield of California PPO Network." Since then, Blue Shield has added a pop-up window that appears at this stage requiring consumers to click a box next to a sentence in small font "agreeing" that the consumer understands the risks of searching for providers without selecting one of the 35 plans on the drop-down menu.

82. According to statements viewable on the Blue Shield website at all relevant times:

> Blue Shield has a great group of doctors and hospitals, such as Scripps, Sutter, and St. Joseph, to name a few. And with a Blue Shield PPO, you can see non-network doctors.
>
> […]
>
> Our extensive network coverage gives our members access to choose from one of the largest provider networks wherever they live or work.
>
> […]
>
> Blue Shield of California networks are some of the largest in California. […]



1 [T]he PPO network includes more than 60,000 physicians and 351 hospitals.

2 83. According to statements made in Blue Shield television advertisements, Blue
3 Shield offers "one of the largest networks in the state."

4 84. According to statements viewable on the Covered California website at all relevant times:

5
6
7
> [Blue Shield is] offering a Preferred Provider Organization (PPO) plan that gives Covered California customers a choice of high-quality doctors and hospitals at an affordable price. We have the top doctors in California.

8 85. Contrary to Blue Shield's representations, concealments, and/or failures to
9 disclose, Plaintiffs had available to them only a very narrow network of providers that was
10 substantially lesser than the traditional "large, high-quality" Blue Shield PPO network that, for
11 years, backed all Blue Shield PPO plans, regardless of whether they were individual plans or employer-based plans.

12 86. At all relevant times, Blue Shield had or should have had full knowledge of the
13 extent of its narrow network as well as the identities of those providers participating in it.

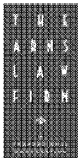
14
D. Blue Shield's Evidences of Coverage Fail to Disclose the Nature of the Provider Networks.

15 87. At all relevant times, Blue Shield has provided and continues to provide its
16 members, including Plaintiffs, with a document known as an "Explanation of Coverage and
17 Health Service Agreement," "Evidence of Coverage," or "EOC." This document purports to
18 inform members of "which services are Covered Services, and the limitations and exclusions that
19 apply to the plan." The EOC states the following:

20
21
> As a Blue Shield Subscriber, you have the right to: [...] Receive information about your Blue Shield plan, the services we offer you, the Physicians and other practitioners available to care for you.
>
> [...]

22
23
24
> Blue Shield Participating Providers include primary care Physicians, specialists, Hospitals, Alternate Care Service Providers, and Other Providers that have a contractual relationship with Blue Shield. Participating Providers are listed in the Participating Provider directory.
>
> [...]

25
26
27
28
> Participating or Preferred (Participating Provider or Preferred Provider) – refers to a provider who has contracted with Blue Shield to accept Blue Shield's payment, plus any applicable Member Deductible, copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services



provided to Members.

88. The EOC also instructs members to "[c]all Customer Service or visit www.blueshieldca.com to determine whether a provider is a Participating Provider."

89. Blue Shield conceals or fails to disclose in these excerpts or in any part of the EOC that there is not a singular Blue Shield network of providers, but rather, multiple networks of providers, some of which, including those available to Plaintiffs, are significantly lesser than the traditional, large Blue Shield of California PPO provider network marketed on Blue Shield's website. Blue Shield further concealed or failed to disclose that, although providers may "have a contractual relationship with Blue Shield," thus meeting the EOC's definition of "Participating Provider", the contract may only be for the provision of care to members of employer plans. Blue Shield also concealed or failed to disclose that the providers who truly are participating in the narrow network may "opt out" of that network up to a certain date each year. Therefore, members could confirm that a provider is in network for their particular plan only to find out later that the provider has opted out of the network since the member last checked.

E. Plaintiffs

1. Plaintiff John Harrington

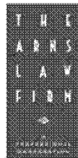
90. For a period of time prior to December 2013, John Harrington did not have healthcare coverage and would be subject to penalty unless he purchased a health service plan before the end of the 2014 Open Enrollment Period.

91. On or around December 28, 2013, Harrington signed up for Covered California on the Covered California website and purchased a health service plan from Blue Shield.

i. While interacting with the Covered California website, Harrington used a "Shop and Compare Tool" designed to show users the plans offered through Covered California. One such plan was the Blue Shield "Enhanced Silver 73 PPO" plan. Harrington purchased this plan.

ii. Harrington chose a Blue Shield PPO health service plan in part because of numerous representations that the Blue Shield PPO network included and would include providers from whom he wished to receive medical treatment.

iii. In January 2014, Harrington required and sought medical treatment. He intended to



use his Blue Shield health service plan to cover this treatment.

iv. Prior to beginning treatment, Harrington researched providers on the Blue Shield website and identified providers from whom he wished to receive treatment. These providers' names and addresses appeared on the Blue Shield website as providers that accepted his plan or were within the Blue Shield of California PPO network and, thus, appeared to him to be included within the network of providers from whom he could receive treatment.

v. Harrington contacted the providers prior to commencing treatment with the providers and confirmed that they were members of Blue Shield's PPO network and they accepted his Blue Shield health service plan.

vi. By the time of his appointments, Harrington had still not received his enrollment ID card, despite having paid his premium. Because he did not have proof of his health coverage at the time of these appointments, Harrington was required to pay for the visits, out-of-pocket, before the doctor would see him.

vii. Harrington received treatment from the above-mentioned providers on various occasions from January 2014 through March 2014. He believed at all times that his Blue Shield health service plan would pay all or most of the bills for this treatment.

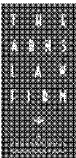
viii. After receiving treatment from the abovementioned providers, Harrington requested Blue Shield pay his providers for the treatment rendered. Blue Shield informed Harrington that the providers who treated him were not, in fact, members of the Blue Shield provider network available to him and that Blue Shield was denying coverage for this treatment at the in-network level of benefits.

ix. Harrington was required to pay out-of-pocket for the medical treatment he received from the above-mentioned providers because of Blue Shield's denial of coverage and refusal to pay.

2. Plaintiff Alex Talon

92. In January 2014, Alex Talon purchased a health service plan from Blue Shield on the Blue Shield website. Prior to this, Talon had health coverage through Kaiser Permanente.

i. While interacting with the Blue Shield website, Talon viewed an html comparison of the various plans offered by Blue Shield. One such plan was the "Ultimate Plan



(Platinum 90)" plan, which he purchased.

ii. Talon chose a Blue Shield PPO health service plan in part because of various representations that the Blue Shield PPO network was expansive and would include providers from whom he wished to receive medical treatment.

iii. In January 2014, Talon required and sought medical treatment. He intended to use his Blue Shield health service plan to cover this treatment.

iv. Prior to beginning treatment, Talon researched providers on the Blue Shield website and identified providers from whom he wished to receive treatment. These providers' names and addresses appeared on the Blue Shield website as providers that accepted his plan or were within the Blue Shield of California PPO network and, thus, appeared to him to be included within the network of providers from whom he could receive treatment.

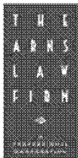
v. Talon contacted the providers prior to commencing treatment with the providers and confirmed that they were members of Blue Shield's PPO network and they accepted his Blue Shield health service plan.

vi. Talon contacted Blue Shield prior to commencing treatment and confirmed that the providers he wished to see were members of the Blue Shield PPO network and accepted his Blue Shield health service plan.

vii. Talon received treatment from the above-mentioned providers on various occasions from January 2014 through March 2014. He believed at all times that his Blue Shield health service plan would pay all or most of the bills for this treatment.

viii. After receiving treatment from the abovementioned providers, Talon requested Blue Shield pay his providers for the treatment rendered. Blue Shield informed Talon that the providers who treated him were not, in fact, members of the Blue Shield provider network available to him and that Blue Shield was denying coverage for the treatments at the in-network level of benefits.

ix. Talon was further informed that the Blue Shield health service plan he purchased was considered a Covered California plan, despite the fact that Talon was never informed at any time that the health service plan he was purchasing was in any way affiliated with Covered California.



x. Additionally, Talon was informed that the Blue Shield health service plan he purchased offered access to only one physician in the City of San Francisco who practiced medicine within the field of the treatment he required, whereas the Blue Shield PPO network he believed he purchased appeared to offer access to numerous such physicians.

xi. Talon was required to pay out-of-pocket for the medical treatment he received from the above-mentioned providers because of Blue Shield's denial of coverage and refusal to pay.

xii. Since then, Talon has incurred additional out-of-pocket bills from services rendered by providers he believed to be in his plan's network, which he has paid in full so as to prevent a negative effect on his credit score.

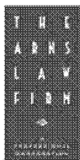
3. Plaintiff Daniel Sullivan

93. Daniel Sullivan was a member of Blue Shield under an individual PPO plan for the last three to four years.

i. In or around November or December 2013, Sullivan received the above-described letter from Blue Shield notifying him that his PPO health service plan would be cancelled and no longer effective after December 31, 2013. The letter stated that beginning January 1, 2014, Blue Shield would be offering "new quality health plans" with "expanded levels of coverage" and suggested a "recommended new plan option" for Sullivan that Blue Shield selected as a "good fit" for Sullivan and his family. Blue Shield instructed Sullivan to simply continue paying his monthly premiums at the new rate in order to "continue your Blue Shield coverage in 2014" under the recommended new plan.

ii. This letter was accompanied by the Blue Shield brochure, also described above, which provided an overview of health reform in 2014 and the new ACA-compliant plans.

iii. After receiving the letter, Sullivan called Blue Shield and spoke to a customer service representative about his recommended plan and the other available plans. Sullivan specifically asked what would be different under the new plan. The Blue Shield representative explained benefit and coverage details in depth but never mentioned anything about a different or smaller provider network. The Blue Shield representative



assured Sullivan that the new plan would provide access to the "biggest provider network [Blue Shield] ha[s]."

iv. Sullivan purchased the Blue Shield Platinum PPO plan by continuing to pay his monthly premiums for the plan beginning in December 2013 (for coverage effective starting January 1, 2014).

v. Sullivan chose to continue to subscribe to Blue Shield's health service in part because of his prior experience as a Blue Shield individual PPO policyholder as well as numerous representations made to him by Blue Shield that the accompanying provider network was expansive and included, and would continue to include, providers from whom he or his family had previously received medical treatment and from whom he or his family wished to continue to receive medical treatment.

vi. In or around early May 2014, Sullivan's son, a dependent covered by the plan, required and sought medical treatment. He intended to use his Blue Shield health service plan to cover his son's treatment.

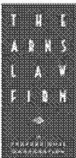
vii. While a member of his previous individual Blue Shield PPO plan in previous years, Sullivan and his family visited the same providers; claims from these providers were processed by Blue Shield as in-network and were fully or mostly covered.

viii. Prior to this treatment, the providers informed Sullivan that they did not accept Covered California plans, including his. Sullivan explained that his plan was not a Covered California plan but that he had purchased it directly from Blue Shield. The providers stated that his plan was a "mirrored" plan, identical to those purchased through Covered California, and that they were not in the network for such plans.

ix. Due to the urgent nature of his son's medical needs, Sullivan directed the providers to treat his son.

x. Sullivan's son received treatment from the above-mentioned providers in May 2014.

xi. After receiving treatment from the above-mentioned providers, Sullivan requested Blue Shield pay for the treatment rendered. Blue Shield informed Sullivan that the providers who treated him were, in fact, not members of the Blue Shield PPO network available to him and that Blue Shield was denying coverage for the treatment at the in-network level of benefits.



1 2 3 xii. Sullivan was required to pay out-of-pocket for the medical treatments he received from the above-mentioned providers because of Blue Shield's denials of coverage and refusals to pay.

4 4. <u>Plaintiff Kieran Turner</u>

5 6 94. Kieran Turner has been a member of Blue Shield under an individual PPO plan since 2001.

7 8 9 10 11 12 13 i. In or around November or December 2013, Turner received the above-described letter from Blue Shield notifying him that his individual PPO health service plan would be cancelled and no longer effective after December 31, 2013. The letter stated that beginning January 1, 2014, Blue Shield would be offering "new quality health plans" with "expanded levels of coverage" and suggested a "recommended new plan option" for Turner that Blue Shield selected as a "good fit" for Turner. Blue Shield instructed Turner to simply continue paying his monthly premiums at the new rate in order to "continue your Blue Shield coverage in 2014" under the recommended new plan.

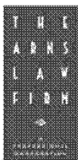
14 15 ii. This letter was accompanied by the Blue Shield brochure, also described above, which provided an overview of health reform in 2014 and the new ACA-compliant plans.

16 17 18 iii. After receiving the letter, Turner logged into his Blue Shield account on the Blue Shield website. He discovered that Blue Shield had already issued a new individual PPO plan in his name slated to begin coverage as of January 1, 2014.

19 iv. While interacting with the Blue Shield website, Turner viewed an html comparison of the various plans offered by Blue Shield for 2014.

20 21 22 23 24 25 26 27 v. Turner called Blue Shield and spoke to a customer service representative about his recommended plan and the other available plans. Turner specifically asked what would be different under the new plan. The Blue Shield representative explained benefit and coverage details in depth but never mentioned anything about a different or smaller provider network. The Blue Shield representative also expressly assured Turner that the new plan would cover the same doctors as Turner's then-existing PPO, some of whom Turner had been seeing for the entirety of his eleven years as a Blue Shield PPO member.

28 vi. Turner purchased the Blue Shield Enhanced PPO plan by continuing to pay his



monthly premiums for the plan beginning in December 2013 (for coverage effective starting January 1, 2014).

vii. Turner chose to continue to subscribe to Blue Shield's healthcare service in part because of his prior experience as a Blue Shield individual PPO policyholder as well as numerous representations made to him by Blue Shield that the accompanying provider network was expansive and included, and would continue to include, providers from whom he had previously received and wished to continue to receive medical treatment.

viii. In January 2014, Turner required and sought medical treatment. He intended to use his Blue Shield health service plan to cover this treatment.

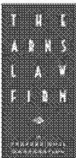
ix. While subscribing to his previous individual Blue Shield PPO plan in previous years, Turner visited the same providers for the same services on many occasions. On each occasion, the providers' claims were processed by Blue Shield as in-network and were fully or mostly covered.

x. Turner received treatment from the above-mentioned providers on various occasions in January through April 2014. He believed at all times that his Blue Shield plan would pay all or most of the bills for this treatment.

xi. After receiving treatment from the above-mentioned providers, Turner's providers requested Blue Shield pay for the treatment rendered. Blue Shield informed Turner that the providers who treated him were, in fact, not members of the Blue Shield PPO network available to him and that Blue Shield was denying coverage for the treatments at the in-network level of benefits.

xii. In or around early June 2014, Turner phoned Blue Shield. The customer service representative was unable to tell Turner whether his providers were in network. Turner called back and spoke to a different representative who confirmed the providers' out-of-network status.

xiii. After this phone call, Turner researched whether his other long-time doctors were in his narrow network. He logged into his Blue Shield account on Blue Shield's website and used the "Find a Provider" tool, which indicated that they were participating members for his plan. When he contacted these providers directly, however, he



learned that the Blue Shield directory was inaccurate and that they were not accepting his plan.

xiv. Turner was required to pay out-of-pocket for the medical treatments he received from the above-mentioned providers because of Defendants' denials of coverage and refusals to pay.

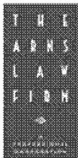
xv. From April through July 2014, Turner continued his effort to obtain an accurate and reliable list of providers who were included in his plan's narrow network. He is hesitant to seek any further medical treatment due to Blue Shield's repeated inaccurate and unreliable representations as to whether certain providers are in this new narrow network.

5. Plaintiff Jon Daum

95. Before January 1, 2014, Jon Daum was insured through United Healthcare on a policy that included himself, his wife and two sons. He received notice in the fall of 2013 that their health service plan was being cancelled. On or about October 2013, Daum began researching other health service plans for his family.

i. Daum researched various health service plans to verify that his family's medical providers were within the network of physicians in the new health service plan he selected. In order to verify that this Blue Shield plan would offer in-network provider benefits for his family's medical providers, he checked online through Blue Shield's website, contacted his providers, and engaged a health service plan agent to assist him in selecting the appropriate plan for his family's needs. Having his and his family's current providers covered and included in the network of any new health service plan was of critical importance to him.

ii. He narrowed his choice to a Blue Shield Platinum PPO plan which Blue Shield represented included the providers from whom he wished to receive medical treatment. Blue Shield sent Daum a list of covered providers, and assured him they would continue into 2014. This list of providers included those physicians he and his family



were existing patients to, and any other specialists they could feasibly foresee needing services from.

iii. A representative from Blue Shield told Daum over the phone that the list of providers given to him would continue unchanged in 2014.

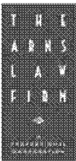
iv. Based on the representations made by Blue Shield that his family's medical providers would be in network on this Blue Shield plan, he contracted with Blue Shield for coverage to begin January 1, 2014.

v. Thereafter, Daum, and his covered family members, sought medical care from the medical providers previously verified to be within their Blue Shield plan's network. At all times Daum reasonably believed the providers seen by him and his family were covered under the Blue Shield Platinum PPO.

vi. Following the medical care from these providers, Daum, and his covered family members, began receiving bills from the providers, and later, creditors.

vii. It was Daum's understanding that all services provided by the listed providers would be paid in full by insurance, minus any copay obligations. Had Daum been informed of the providers' out-of-network status, he and his family would not have used the services.

viii. Daum verified on several occasions through Blue Shield's website, providers and through his agent that his providers were in network. It was only after he began receiving unpaid bills that he learned Blue Shield was considering his physicians out of network or that they had been dropped from Blue Shield's list of in-network providers. At no time was this information given to him prior to the closing of the Open Enrollment Period. As a result of the conduct of Blue Shield, Plaintiff Daum and his family members were forced to pay bills for which coverage was wrongfully denied and suffered damage to their credit.



6. Plaintiff Steven Yerkes

96. Before January 1, 2014, Steven Yerkes was insured through Blue Cross under a policy that included him and his wife. In the winter of 2013, he engaged the services of a health care service plan agent to assist him in obtaining a new health service plan.

i. Yerkes provided his health care service plan agent with a list of all of his and his wife's medical providers. The agent then researched various health service plans to verify that his family's medical providers were within the network of physicians in the new health service plan he selected.

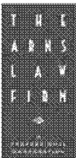
ii. Based on the representations made by Blue Shield that his family's list of medical providers would be in network on the Blue Shield Silver PPO plan, Yerkes contracted with Blue Shield for coverage to begin January 1, 2014.

iii. Thereafter, Yerkes and his wife sought medical care from the medical providers originally verified to be within Blue Shield's in-network provider list.

iv. Yerkes visited his physician on multiple occasions beginning in or around late January 2014. Prior to visiting this provider, Yerkes had confirmed coverage through the Blue Shield website, health service plan agent, and the provider's office. Approximately three weeks after Yerkes' visit, he received a denial of benefits from Blue Shield stating that no payment would be made for his provider visit as the provider was out of network. In fear of the bill having adverse financial effects, Yerkes paid the provider's bill in full.

v. On two following occasions, Yerkes confirmed coverage for other providers with whom he was setting appointments. After setting these appointments, but before attending them, Yerkes was notified that his providers were in fact, not going to be covered as in network and his appointments were cancelled. He was forced to find alternative physicians who Blue Shield would pay as in-network providers.

vi. Yerkes was also informed that the Blue Shield health service plan he had purchased was considered a Covered California plan, even though Yerkes was never told that the



health service plan he was purchasing was in any way affiliated with Covered California. This resulted in multiple providers who were in the network advertised by Blue Shield denying him coverage for treatment that should have been covered.

vii. Following the medical care from these providers, Yerkes and his wife began receiving bills from the providers and learned that they were in fact out-of-network providers or had been dropped from Blue Shield's list of in-network providers after the Open Enrollment Period had closed.

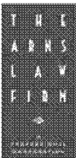
7. Plaintiff Erin Harvey

97. Before January 1, 2014, Plaintiff Harvey was insured through a Blue Cross PPO policy. She was pregnant at the time with a due date in the spring 2014. In the winter of 2013, she engaged the services of a health care service plan agent to assist her in obtaining a new health service plan.

i. Harvey provided her health care service plan agent with a list of all of her medical providers, including UCSD, where she was receiving prenatal care and would deliver her baby. The agent then researched various health service plans to verify that her medical providers were within the network of physicians for the new health service plan she selected. Based on the representations made by Blue Shield that UCSD would be in network under the Blue Shield Gold 80 PPO Plan, she contracted with Blue Shield for coverage to begin January 1, 2014.

ii. Based upon the representations by Blue Shield that her providers were in-network, Harvey continued to receive prenatal care in preparation for the delivery of her baby.

iii. Thereafter, Harvey delivered her son at UCSD and he required an eight-day stay in the neonatal intensive care unit before he could be released home. Following the hospitalization for Harvey and her newborn son, Harvey began receiving bills from UCSD, and related medical providers. When the bills went unpaid, Harvey was told—well after she purchased her plan, Open Enrollment had closed, and the birth of her new



baby—that the hospital and the providers were not in network. Harvey was forced to pay the bills to protect her credit.

iv. To Harvey's knowledge, UCSD was also unaware that Blue Shield was no longer covering their providers as in network, until Harvey had to explain to UCSD why her bills were outstanding.

v. During this time, Harvey did not receive notifications from Blue Shield about her provider network status or lack of coverage.

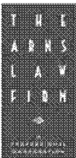
vi. Blue Shield paid only the minimal out-of-network provider amounts for the services rendered to Harvey by UCSD and related providers. Harvey ultimately paid out-of-pocket for the treatment received from her providers because of Blue Shield's denial of coverage and refusal to pay.

8. <u>Plaintiffs Kevin and Jane McCarthy</u>

98. Near the end of 2013, Kevin and Jane McCarthy received a notice from their insurer, Aetna, that their existing individual health service plan was being canceled because the company was withdrawing all of its individual health service plans from the California market. The McCarthys started shopping for a new health service plan.

i. It was important to the McCarthys that their longtime physicians, Dr. Levy and Dr. Yaftali, were both in-network under their new health service plan.

ii. While researching available health service plans, Jane visited Blue Shield's website and used Blue Shield's provider search tool, which listed both Dr. Levy and Dr. Yaftali as in-network providers under Blue Shield's "Silver Enhanced PPO" plan. Jane also called Dr. Levy and Dr. Yaftali and they both confirmed that they would accept Blue Shield's "Silver Enhanced PPO" plan. Based on Blue Shield's representations that Dr. Levy and Dr. Yaftali were in-network, the McCarthys decided to enroll in the Silver Enhanced PPO health service plan in December 2013.

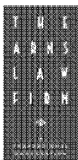


iii. Blue Shield's Silver Enhanced PPO has an annual deductible of $2,000 per individual, which means that Kevin and Jane must each pay $2,000 out-of-pocket before Blue Shield will begin to pay for certain covered services. Under their plan, payments the McCarthys make to out-of-network providers do not count toward satisfying their individual $2,000 annual deductibles. If the McCarthys ever meet their annual deductibles, Blue Shield will only cover 50% of the "allowed amount" of a covered service rendered by an out-of-network provider.

iv. Also, Blue Shield's Silver Enhanced PPO has two out-of-pocket maximum amounts, beyond which the member pays nothing: for in-network provider services, the out-of-pocket maximum is $6,350 per individual; for out-of-network provider services, the out-of-pocket maximum is $9,350 per individual. The out-of-pocket maximum is the most a member should expect to pay out-of-pocket annually. Under their plan, payments the McCarthys make to out-of-network providers do not accrue toward their individual $6,350 in-network, out-of-pocket maximum amounts.

v. In late March 2014, Kevin visited Dr. Yaftali for routine medical tests. Kevin subsequently received an Explanation of Benefits ("EOB") from Blue Shield for his March 2014 visit to Dr. Yaftali, which listed Dr. Yaftali as out-of-network. The EOB showed that Blue Shield was only covering $16.46 of the $100 bill and that Kevin was responsible for paying the remaining $83.54 out-of-pocket, and none of that amount would be applied to satisfy his deductible or accrue toward his $6,350 in-network, out-of-pocket maximum.

vi. Kevin and Jane both called Blue Shield many times to inquire about the out-of-network charges for Kevin's visit with Dr. Yaftali. Each time they called Blue Shield, they experienced hold times lasting two to four hours. Because of these excessive hold times, the McCarthys had to schedule blocks of time where they would stop running their small business in order to call Blue Shield to ask about the



out-of-network charges. The McCarthys lost business as a result of the time they spent on hold with Blue Shield.

vii. When the McCarthys were able to connect to live Blue Shield customer service representatives, they received inconsistent information. During one phone call, a representative assured Jane that Dr. Yaftali was an in-network provider. But, during a later phone call, Blue Shield said that Dr. Yaftali was not in-network. During these phone calls, Blue Shield told Jane that her doctor, Dr. Levy, was no longer in-network under their PPO plan.

viii. Kevin subsequently returned to the Blue Shield website, which no longer listed Dr. Yaftali as an in-network provider.

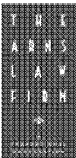
ix. Eventually, Kevin connected with a Blue Shield representative over the phone who said that Blue Shield would cover 50% of Kevin's March 2014 bill for Dr. Yaftali, but that this was a "one-time" offer.

x. Kevin considered switching to a different provider who was in-network under his Blue Shield plan. According to Blue Shield's website, however, the nearest in-network providers were located in another county more than 30 miles away.

xi. In early May 2014, Kevin saw Dr. Yaftali for a follow-up appointment. Kevin later received an EOB from Blue Shield showing that he was responsible for charges from his appointment with Dr. Yaflati at the full out-of-network rate. Kevin paid these charges out-of-pocket.

xii. Kevin filed a grievance with Blue Shield on May 7, 2014, requesting that Blue Shield cover services from Dr. Yaftali and Dr. Levy at the in-network rate. Blue Shield responded with a letter that said Blue Shield's Enhanced PPO's network consisted of a "selected network" of providers and Dr. Yaftali and Dr. Levy were not within this "selected network."

xiii. On June 3, 2014, Jane visited a neurologist because of her chronic migraines. Before Jane scheduled this appointment, she confirmed with a Blue Shield customer service



agent that this neurologist was an in-network provider. However, the neurologist told Jane during the visit that the office no longer accepted Jane's Blue Shield PPO plan. No provider in the entire medical center where the neurologist worked accepted Jane's Blue Shield health service plan. Jane paid for this visit out-of-pocket.

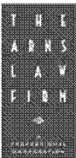
xiv. The McCarthys have incurred and continue to incur hundreds of dollars in medical bills for Dr. Yaflati, Dr. Levy and other out-of-network providers that Blue Shield previously represented as in-network.

9. Plaintiff Sally Greer

99. In October of 2013, Greer enrolled in a Blue Shield Silver PPO individual health service plan through the Covered California exchange. The plan went into effect on January 1, 2014.

i. In or about December of 2013, Greer checked the provider search function of Blue Shield's website and confirmed that health care providers at the University of California Irvine ("UCI") were in-network providers for the plan in which she enrolled. She also checked the website and confirmed that a particular UCI infectious disease doctor, Dr. Catherine Diamond, was an in-network provider. It is and was important to Greer that these doctors are in-network providers as they are geographically close to where she lives and because her previous doctors recommended the UCI providers as the doctors believe that the UCI doctors have the best resources available to treat Greer's existing ailments and medical conditions.

ii. During December of 2013, Greer attempted to call Blue Shield to confirm that coverage under her Blue Shield plan would begin on January 1, 2014 and that her first payment had been accepted. It took her numerous calls that spanned multiple hours before she reached a Blue Shield representative who was able to provide her with the confirmation that she sought.



iii. In January of 2014, Greer went on Blue Shield's website and again confirmed that the infectious disease doctor, Dr. Catherine Diamond, from whom she wanted to seek treatment, was an in-network provider. Relying upon this information, Greer visited Dr. Diamond for treatment in early February of 2014. Unfortunately, this doctor was not an actual in-network provider for Greer's Blue Shield health plan and UCI was not a contracted in-network facility. As a result, Greer is now responsible for costs of the services that she otherwise would not have been required to pay had her providers been in-network as Blue Shield represented they were.

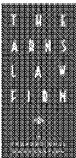
iv. Greer also incurred additional bills as a result of Blue Shield's misrepresentations. After Greer's appointment, Dr. Diamond referred her to see another UCI doctor whom she saw in February of 2014 and who subsequently referred Greer to physical therapy and two specialists at UCI's eye institute. Shortly after, Greer saw the two UCI specialists, had blood work conducted, and made an appointment for physical therapy at UCI. Unfortunately, despite Blue Shield's representations to the contrary, these healthcare professionals also were not in-network and, as a result, Greer has incurred out-of-pocket costs for their services and had to cancel future appointments for necessary treatments.

10. <u>Plaintiffs Tiemo Mehner and Cynthia Carlson</u>

100. Plaintiffs Mehner and Carlson paid premiums for months and never received their enrollment ID cards.

i. In early December 2013, Mehner and Carlson signed up for the "Blue Shield – Bronze 60 PPO" individual health service plan through the Covered California exchange website.

ii. On December 30, 2013, Mehner and Carlson received a letter from Blue Shield, dated December 20, 2013, informing them that their application for health coverage had been received and that they should make a payment by December 21, 2013 to



complete enrollment. Mehner immediately made a payment via credit card on Blue Shield's website, and his card was charged for the payment on January 2, 2014.

iii. In a letter dated January 7, 2014, Blue Shield stated "[y]our coverage effective date is January 1, 2014." Blue Shield also stated, "Please note that ID cards and certificates will be sent under separate cover." As of the end of January 2014, Mehner and Carlson still had not received ID cards.

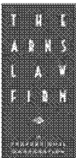
iv. On February 19, 2014, Mehner and Carlson received a letter from Blue Shield, dated February 8, 2014, stating that Blue Shield had not received their payment and "immediate action is needed … [i]f you would like to continue your coverage(s)[.]" Mehner immediately sent a payment by check, and Blue Shield deposited the check on February 26, 2014. As of the end of February 2014, Mehner and Carlson still had not received ID cards.

v. In a letter dated March 7, 2014, Blue Shield again told Mehner and Carlson that it had not received their payment and "immediate action is needed … [i]f you would like to continue your coverage(s)[.]"

vi. Mehner then called Blue Shield and received an automated confirmation that Blue Shield had received all payments and that no payments were due. Still concerned, Mehner called Blue Shield to try and speak with a live customer service representative. After approximately 80 minutes on hold, Mehner reached a live representative who confirmed that Blue Shield had received Mehner and Carlson's payments and said that there had been an error in the system that Blue Shield was working to correct.

vii. As of the end of March 2014, Mehner and Carlson still had not received ID cards. Mehner and Carlson also never received an invoice for their March 2014 premium payment.

viii. On April 19, 2014, Mehner and Carlson received a letter from Blue Shield informing them that their coverage "has been terminated as of February 28, 2014 because we



did not receive your premium payment." Mehner immediately called Blue Shield's customer service telephone line and, after being on hold for 40 minutes, Blue Shield suddenly played an automated message instructing Mehner to call back during business hours and disconnected the call.

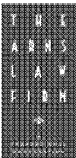
ix. The next day, Mehner called a different health service plan, Anthem Blue Cross, to get information about switching plans. A Blue Cross representative told Mehner that coverage was not available to Mehner and Carlson because their previous health service plan had been terminated due to nonpayment. According to Blue Cross, Mehner and Carlson could not purchase coverage until the next enrollment period.

x. Left with no alternative, Mehner called Blue Shield on April 21, 2014 to try and reinstate his and Carlson's health service plan. Mehner was on hold for approximately 45 minutes before he connected to a live representative, who confirmed that Blue Shield had received the February 2014 payment. The representative told Mehner that he would be contacted by Blue Shield's "Reinstatement Department" within five days, and Mehner would have to pay the accrued balance for their March, April, and May 2014 premiums in order to reinstate coverage.

xi. Having heard nothing from the Reinstatement Department, on April 30, 2014, Carlson called Blue Shield. Carlson was on hold for 50 minutes before she connected to a live representative, who told Carlson that an error had occurred in the Reinstatement Department. When Carlson then tried to make a payment for their March, April, and May 2014 premiums, the Blue Shield representative said she could not process the payment and would call Carlson back. Carlson never heard from the Blue Shield representative.

xii. As of the end of April 2014, Mehner and Carlson still had not received ID cards. Mehner and Carlson also never received an invoice for their April 2014 premium payment.

xiii. On May 1, 2014, Carlson called Blue Shield again to inquire about their coverage.



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After waiting on hold for 55 minutes, a customer service representative promised to expedite Mehner and Carlson's claim with the Reinstatement Department.

xiv. On May 14, 2014, Carlson spoke with a Covered California customer service representative who assured Carlson that she and Mehner would not have to pay penalties under the ACA due to a lapse in coverage, since Blue Shield erred in processing their payments. The Covered California representative started the paperwork to get Mehner and Carlson's coverage "reinstated" with Blue Shield. Carlson was instructed to follow up with Blue Shield. Carlson called Blue Shield and waited on hold for 20 minutes before Blue Shield's telephone system disconnected the call.

xv. Carlson called Covered California and terminated the Blue Shield health service plan because of the misrepresentations. Mehner and Carlson enrolled in an equivalent Health Net plan.

xvi. During this time, Carlson needed to visit a doctor for her annual checkup. She refrained from getting the checkup because she had not received her ID card.

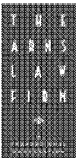
xvii. Mehner and Carlson were never reimbursed by Blue Shield for the premium payments Blue Shield accepted without providing them proof of coverage.

11. Plaintiff Barry Weiss

101. Barry Weiss was fraudulently induced into purchasing a Blue Shield health service plan with a drastically reduced network of providers.

i. On or about January 3, 2014, Weiss applied for a Covered California health plan after researching it on the Blue Shield website. He applied for a Blue Shield PPO premiere plan entitled Ultimate PPO family plan. His coverage began on February 1, 2014.

ii. Prior to his purchase, Plaintiff Weiss searched for and ultimately found his doctors to be purportedly within the network of Blue Shield of California PPO providers after conducting a diligent search of his physicians' names. It was especially important to



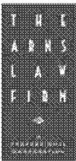
Weiss that his long-time primary physician, Dr. Sylvain Silberstein would be covered. Therefore, he not only checked online, but also called Blue Shield to double check to confirm his doctor's status as in network. Moreover, Weiss called his primary physician who affirmed that Weiss's Blue Shield PPO would cover the applicable services stated in his health care service plan for any visit to his doctor's office.

iii. Weiss was confident after his research that his primary physician would be covered by his Blue Shield PPO plan. Furthermore, Blue Shield's advertising of "one of the largest networks in the state" swayed Weiss to believe that his findings were accurate and that his primary physician and his other doctors he looked up were covered, and in reliance thereon, decided to purchase the PPO health service plan. As a result of Weiss's findings, he bought the Ultimate PPO health service plan through Covered California's website confident that his doctors, including his primary doctor, were in fact covered.

iv. Shortly thereafter Weiss had multiple visits with his primary physician, Dr. Silberstein. Specifically, Weiss had a visit on March 11, 2014 and on April 10, 2014 with Dr. Silberstein, who allegedly was within the network of providers as verified by Defendant's "find a provider" link. Weiss was subsequently charged $345.00 and $350.00, for such visits, because Blue Shield considered Weiss's doctor to be an out-of-network doctor.

v. Plaintiff Weiss filed grievances with Blue Shield when he found that his doctor was in fact not an in-network provider. Blue Shield's response letters were of no help and just explained that because the doctor was a non-preferred provider, the services were paid at such a rate. There was no explanation as to why the provider showed up as a covered provider when in reality they were not.

vi. Weiss also called Blue Shield to inquire about these unfair practices and to inquire about another doctor who he planned to see, Dr. Bahar. Like Weiss's primary care physician, Dr. Bahar appeared as an in-network preferred provider on the Blue Shield Find A Provider website, yet when Weiss called Dr. Bahar, Weiss was told that Dr.



Bahar was in fact not in network. When asking about why this discrepancy was happening, a Blue Shield representative told him that the website is not accurate and that he would have to call Blue Shield to check if a doctor was covered.

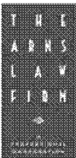
vii. Weiss would not have purchased the particular Blue Shield PPO health care service plan if he knew his doctors, including his primary doctor, were not covered under his plan.

viii. Blue Shield's misrepresentations, concealment, and/or failures to disclose on its website and media advertising led Weiss to believe that the network of providers were true and accurate and that Blue Shield's PPO coverage was as extensive as Blue Shield portrayed. Further, Weiss relied on Defendant's "find a provider" link. Weiss would not have paid as much, if at all, for a health service plan that was more restrictive than advertised but for Defendant's deceptive advertising, concealment, and failure to disclose.

12. Plaintiff Lori Scarpo

102. Lori Scarpo purchased a Blue Shield Gold PPO plan through Covered California that went into effect in January 2014.

i. Before she subscribed to her Blue Shield plan, Scarpo carefully researched Blue Shield's online list of providers to make sure that her physician and other providers were covered as in-network for her plan. Scarpo has several rare allergies, so it was important for her to select a plan where her preferred physicians, hospital, and laboratory testing company would be covered. Blue Shield's website listed her physician, Dr. Julie Delilly in Redondo Beach, California, as in-network for her plan. Scarpo also checked the Blue Shield website to verify that Lab of America in Redondo Beach, CA and Providence Little Company of Mary Medical Center in Torrance, CA would be in her network. Blue Shield's provider finder tool stated that both of these providers were in network for her plan.

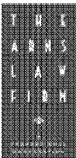


ii. After Scarpo enrolled with Blue Shield, she had several physician appointments and tests with Dr. Delilly, Providence Little Company of Mary Medical Center, and Lab of America. Scarpo relied on the accuracy of Blue Shield's provider lists in determining that these providers were in-network. After Scarpo saw these providers and received bills for services from these providers, Blue Shield told her that all of these providers were out-of-network. Scarpo has had to pay hundreds of dollars in additional medical expenses because her providers were considered out-of-network by Blue Shield, even though Blue Shield listed these providers as in-network providers on their website. Scarpo again checked Blue Shield's website after Blue Shield denied in-network coverage for her claims and Blue Shield continued to list Dr. Delilly, Providence Little Company of Mary Medical Center, and Lab of America as being in-network for her Blue Shield Gold plan, despite Blue Shield's refusal to pay for these providers as in-network.

iii. Scarpo received several erroneous termination notices from Blue Shield due to non-payment, despite the fact that she always made her premium payments on time. Scarpo sent in several faxes from her bank showing that she made her payments. Blue Shield cancelled Scarpo's health service plan on October 31, 2014 due to Blue Shield's assertion that it did not receive her payments for her premiums. On November 14, 2014 Scarpo talked to a supervisor at Blue Shield about her plan's termination. She sent him proof that she had made her payments on time and he told her that he was sending her information to another department and that it would take 72 business hours to reinstate her health service plan. She never received any further information from Blue Shield about reinstating her health service plan. Scarpo has enrolled in a Covered California plan that is not through Blue Shield for 2015.

13. <u>Plaintiff Sheilah Asher</u>

103. Sheilah Asher was a member of a Blue Shield individual PPO plan from 2011 through 2013.



xvi. In or around October 2013, Asher received a letter from Blue Shield notifying her that her individual PPO health service plan would be cancelled and no longer effective after December 31, 2013.

xvii. After receiving the letter, Asher researched what individual plans were available in her county of residence for 2014. Only Blue Shield and Anthem Blue Cross offered individual plans in Amador County in 2014.

xviii. Wanting to continue seeing her established doctors, Asher researched whether her long-time doctors were in network for Blue Shield's Silver EPO plan. She visited Blue Shield's website and used the "Find a Provider" tool, which indicated that her providers were participating members for her plan. When Asher contacted these providers directly, they confirmed this.

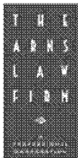
xix. Asher also called Blue Shield and spoke to multiple customer service representatives and a Blue Shield manager about the new EPO plan. Asher specifically asked whether the new plan would cover the same doctors as Asher's then-existing PPO plan, some of whom Asher had been seeing for the entirety of her three years as a Blue Shield PPO member. Blue Shield informed Asher that her providers would be in-network for the EPO plan.

xx. In or around October 2014, Asher enrolled in Covered California on the Covered California website and purchased a Blue Shield health service EPO plan.

xxi. Asher chose to continue to subscribe to Blue Shield's healthcare service in part because of her prior experience as a Blue Shield individual PPO member as well as numerous representations made to her by Blue Shield that the accompanying provider network was expansive and included, and would continue to include, providers from whom she had previously received and wished to continue to receive medical treatment.

xxii. However, in early 2014, Asher learned that the information Blue Shield had given her was inaccurate and that, in fact, her doctors were not members of the Blue Shield EPO network available to her and that Blue Shield would not provide any coverage for care obtained from them.

xxiii. Additionally, Asher was informed that the Blue Shield health service plan she



purchased failed to offer access to even a single surgical oncologist within 50 miles of her house and offered access to only one regular oncologist within 30 miles, whereas the plan Blue Shield promised her offered access to numerous such physicians, including her established providers.

xxiv. In May 2014, Asher required medical treatment from one of the above-mentioned providers. She made an appointment but ultimately cancelled it because the provider was out of network and she could not afford to pay for the visit without coverage from Blue Shield. Asher did not make any further appointments with her previous providers after that.

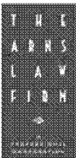
xxv. In October 2014, Asher again required and sought medical treatment. At the time of the appointment, Asher was aware the provider was not in network for her EPO plan. She believed at all times that her Blue Shield plan would not pay for any of the bill for this treatment because the provider was out of network. However, due to the necessary nature of the treatment, Asher went forward with the procedure and paid for it outof-pocket.

xxvi. Asher was required to pay out-of-pocket for the medical treatment she received from the above-mentioned provider because of Blue Shield's misrepresentations.

xxvii. For the remainder of 2014, Asher continued her effort to obtain an accurate and reliable list of providers who were included in her plan's narrow network. She was hesitant to seek any further medical treatment due to Blue Shield's repeated inaccurate and unreliable representations as to whether certain providers are in this new narrow network.

104. Based on the facts stated herein, Plaintiffs purchased health service plans from Blue Shield based on Blue Shield's misrepresentations, concealments, and failures to disclose facts material to their decisions to enter into the transactions. Had Plaintiffs known these facts, they would not have entered into these transactions. Plaintiffs purchased products and services that were inferior to and of lesser economic value than that which Blue Shield led Plaintiffs to believe they were purchasing.

105. Based on the facts stated herein, Plaintiffs suffered actual, measurable economic injury in fact in various forms including, but not limited to, out-of-pocket expenses for medical



treatment and payment of monthly premiums for a product that was of a lesser value than that which they contracted to purchase.

106. Plaintiffs made reasonable efforts including, but not limited to, submitting requests to their medical providers or to Blue Shield directly, to obtain payment or reimbursement from Blue Shield for their medical expenses, but were refused by Blue Shield, thus requiring Plaintiffs to hire attorneys to recovery their damages.

107. In misrepresenting, concealing, or failing to disclose to Plaintiffs the material terms of their health service plans, as well as by committing the numerous other violations detailed below, Blue Shield, by and through their officers, directors and/or managing agents, acted with malice, oppression and/or conscious disregard for the statutory or other rights of Plaintiffs, and committed fraud by knowingly making false misrepresentations to Plaintiffs with the intent to defraud and to the detriment of Plaintiffs. Given the number and magnitude of the violations, as well as the nature of the conduct, an award of punitive damages under Civil Code section 3294, *et seq.* and as otherwise permitted by applicable law is appropriate under all of the circumstances.

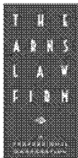
FIRST CAUSE OF ACTION
VIOLATION OF THE CLRA (CIV. CODE, §§ 1750, *ET SEQ.*)

On Behalf of Classes 1, 2, 3, 4, and 5

108. Plaintiffs reallege and incorporate by reference all paragraphs above as if set forth in detail herein.

109. Under Civil Code section 1770, subdivision (a), of the CLRA, the following "unfair methods of competition and unfair or deceptive acts or practices undertaken by any person in a transaction intended to result or which results in the sale or lease of goods or services to any consumer are unlawful":

- "Representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he or she does not have." (Civ. Code § 1770(a)(5).)
- "Advertising goods or services with intent not to sell them as advertised." (Civ. Code § 1770(a)(9).)
- "Representing that a transaction confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law." (Civ. Code § 1770(a)(14).)



- "Inserting an unconscionable provision in the contract." (Civ. Code § 1770(a)(19).)

110. Here, Blue Shield has engaged in the initial offering and monthly transactions with consumer Plaintiffs that were intended to result, or actually resulted, in the sale of services in the form of health service plans.

111. As to Class 1 (Restitution Class), Class 2 (PPO Out-of-Pocket Class), Class 3 (EPO Out-of-Pocket Class), & Class 4 (Rollover Class): In connection with such offers and sales:

i. Blue Shield violated the CLRA, Civil Code section 1770(a)(5) by representing that the health service plans have provider network characteristics and other terms and benefits which they do not have;

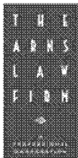
ii. Blue Shield violated the CLRA, Civil Code section 1770(a)(9) by advertising health service plans as having provider network characteristics and other terms and benefits with the intent not to sell them as advertised;

iii. Blue Shield violated the CLRA, Civil Code section 1770(a)(14) by representing that the transactions wherein Plaintiffs purchased Blue Shield's health service plans or sought medical treatment or coverage under Blue Shield's health service plans conferred or involved rights, remedies, or obligations, specifically a network of providers that would be available to Plaintiffs and coverage for medical treatment by such providers, that it did not have or involve.

iv. Blue Shield violated the CLRA, Civil Code section 1770(a)(19) by adopting unconscionable contract provisions adopting inadequate provider networks, and concealing material terms of the coverage.

112. As to Class 5 (Delayed Enrollment Class): In connection with such offers and sales:

i. Blue Shield violated the CLRA, Civil Code section 1770(a)(14) by representing that the transactions wherein Plaintiffs purchased Blue Shield's health service plans conferred

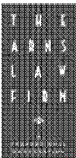


or involved rights, remedies, or obligations, specifically coverage that would be available to Plaintiffs for medical treatment, that it did not have or involve by virtue of Blue Shield's failure to provide ID cards.

113. Such acts and practices were designed or intended by Blue Shield to convince Class members to initially purchase and renew their health service plan contracts each month.

114. Such acts and practices were designed or intended by Blue Shield to convince Class members to initially purchase and renew their health service plan contracts each month. For purposes of the CLRA, a "'[t]ransaction' means an agreement between a consumer and any other person, whether or not the agreement is a contract enforceable by action, and includes the making of, and the performance pursuant to, that agreement." (Civil Code § 1761(e).) The CLRA "shall be liberally construed and applied to promote its underlying purposes, which are to protect consumers against unfair and deceptive business practices and to provide efficient and economical procedures to secure such protection." Here, the "transactions" at issue governed by the CLRA include both the original sale and the renewals of the individual EPO and PPO health service plan contracts made and entered into by Blue Shield, Plaintiffs and Class members, as well as Blue Shield's performance of its obligations under such agreements. In making decisions whether to initially purchase and renew their health service plan contracts, and pay the rates imposed by Blue Shield, Plaintiffs and other Class members reasonably acted in positive response to Blue Shield's misrepresentations as set forth in detail herein, or would have considered the omitted facts detailed herein material to their decisions to do so.

115. Section 1761, subdivision (b), of the CLRA defines "services" as "work, labor, and services for other than a commercial or business use, including services furnished in connection with the sale or repair of goods." Blue Shield's ongoing "work and labor" to establish, maintain, and improve provider networks of hospitals and doctors is the core of the PPO and EPO health service plans at issue here. Blue Shield provides extensive services that do not exist for consumers enrolled in pure indemnity coverage like life insurance. For example:



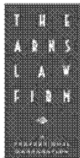
- Blue Shield advertises its EPO and PPO coverage by promoting the network services it provides and the "work and labor" Blue Shield expends in order to guarantee quality and provide consumer choice. Blue Shield's website promises consumers: "easy access to a broad range of doctors, specialists and hospitals. Our providers meet stringent credentialing standards and include some of the most prestigious hospitals in the state … We actively help our members find access to quality care in a variety of ways." Blue Shield's "work and labor" to certify the "quality" of its health care providers is not available to consumers enrolled in indemnity insurance policies.

- The central purpose of the EPO and PPO contracts between Blue Shield and Class members is Blue Shield's provision of work, labor and services in connection with establishing and maintaining on-going access to its network of "preferred providers," which include doctors and hospitals throughout the state. In order to access the key benefits of the health service plan contracts, a consumer must pay a monthly rate to Blue Shield and visit one of the preferred providers in Blue Shield's network. For example, ". . . Blue Shield [] contracts with each individual preferred provider physician to accept those fixed fees as payment in full" for medical care provided to PPO members (Gasparovich, Preferred Provider Organizations Providing Contracting: New Analysis Under the Sherman Act (1985) 37 Hastings L.J. 377, 380, emphasis added). "Under Blue Shield's preferred provider plans, a preferred provider is prohibited from engaging in any balance billing to the patients, and any co-payment received from the patient, as required for certain services, is deducted from the contract-specified fee." (*Id.*)

- Blue Shield's work and labor to maintain those networks require Blue Shield to engage in substantial contract negotiations with physician groups and hospitals that can last more than a year. Patients seeking ongoing treatment from those providers and who would be required to "pay significantly more for services from non-preferred providers" if contract disputes are not resolved. (*Rubinstein Physical Therapy v. PTPN, Inc.* (2007) 148 Cal.App.4th 1130, 1136, review denied.)

- In an effort to attract new customers and retain existing members, Blue Shield expends significant "work and labor" essential to maintaining and improving its provider networks by sponsoring initiatives aimed at providing integrated, cost efficient health care, improving quality and efficiency of health care to ensure it stays affordable for Blue Shield members, reducing costs and lowering rates, as well as developing and implementing integrated advanced technology systems for California that will allow doctors, hospitals and health plans to coordinate and improve health treatment outcomes. (*See generally* https://www.blueshieldca.com/bsca/about-blueshield/ newsroom/home.asp).

116. The services at issue here are not "ancillary services." Instead, the services



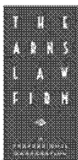
discussed above are the core of the Plaintiffs' EPO and PPO health service plans. The services Blue Shield provides cannot be monetized, assigned, treated as an asset, or borrowed against in the manner that pure indemnity insurance, such as life insurance, can be, and are thus further distinguishable from pure indemnity insurance.

117. Blue Shield violated the CLRA by committing unfair and deceptive acts that directly undermined Plaintiffs' and Class members' ability to access the provider network they were promised. Blue Shield's unfair and deceptive acts increased patients' costs when accessing provider networks and unilaterally reduced treatments and services available from those provider networks.

118. Plaintiffs and Class members have suffered harm as a result of these violations. Plaintiffs purchased and renewed individual health service plan contracts, reasonably relying on Blue Shield's material misrepresentations and omissions, inter alia, that certain providers would be in-network. Plaintiffs and Class members have suffered actual measurable economic injury in fact in various forms including, but not limited to, out-of-pocket expenses for medical treatment and payment of monthly premiums for a product that was of a lesser value than that which they contracted to purchase. Plaintiffs and Class members have also suffered transactional costs by expending time and resources in the form of correspondence and telephone conversations with Blue Shield's customer service representatives in an attempt to avoid the consequences of Blue Shield's unfair methods of competition and unfair or deceptive acts. Plaintiffs and Class members have also suffered opportunity costs by foregoing the opportunity to switch to other coverage offered by other companies during the Open Enrollment Periods.

119. Blue Shield's misrepresentations and omissions described in the preceding paragraphs were intentional, and made with actual knowledge of their falsity, or alternatively, made without the use of reasonable procedures adopted to avoid such an error or with reckless disregard or deliberate ignorance of whether or not they were false. Blue Shield's misrepresentations, failures to disclose, and concealment of the true facts were material.

120. Blue Shield, directly or indirectly, has engaged in substantially similar conduct to



Plaintiffs and to each member of the Class.

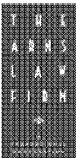
121. Such wrongful actions and conduct are ongoing and continuing. Unless Blue Shield is enjoined from continuing to engage in such wrongful actions and conduct, the public will continue to be harmed by Blue Shield's conduct.

122. Defendants, and each of them, aided and abetted, encouraged and rendered substantial assistance in accomplishing the wrongful conduct and their wrongful goals and other wrongdoing complained of herein. In taking action, as particularized herein, to aid and abet and substantially assist the commission of these wrongful acts and other wrongdoings complained of, each of the Defendants acted with an awareness of its primary wrongdoing and realized that its conduct would substantially assist the accomplishment of the wrongful conduct, wrongful goals, and wrongdoing.

123. Plaintiffs and the Class are entitled to an injunction, pursuant to Civil Code section 1780, prohibiting Blue Shield from continuing to engage in the above-described violations of the CLRA.

124. Blue Shield's conduct as described herein was intended by it to cause injury to members of the Class and/or was despicable conduct carried on by Blue Shield with a willful and conscious disregard of the rights of members of the Class, subjected members of the Class to cruel and unjust hardship in conscious disregard of their rights, and was an intentional misrepresentation, deceit, or concealment of material facts known to Blue Shield with the intention to deprive Class members of property or legal rights, or to otherwise cause injury, such as to constitute malice, oppression or fraud under Civil Code section 3294, thereby entitling Plaintiffs and members of the Class to exemplary damages in an amount appropriate to punish or set an example of Blue Shield.

125. Plaintiffs have complied with Civil Code section 1782(a). Attached as Exhibit 1 to this complaint is a true and correct copy of the 30-day notice letter Plaintiffs Harrington and Talon sent to Blue Shield on May 13, 2014 by certified mail. As of the date of this Consolidated Complaint, Blue Shield has failed to provide all requested relief in response to that notice.



Therefore, Plaintiffs and Class members seek general, actual, consequential, punitive, and statutory damages as well as equitable relief in the form of restitution of all monies paid for health service plans that are substantially different and lesser than what they bargained for and all out-of-pocket costs paid by Plaintiffs and Class members for covered services rendered by providers that they reasonably believed to be participating providers and which would have been covered were the providers actually in-network, an injunction to prevent Blue Shield from engaging or assisting in these illegal practices, and all appropriate fees and costs as are permitted, including those permitted by Civil Code section 1780.

126. Plaintiffs have executed and filed the Declarations in Lieu of Affidavit of Venue in compliance with Civil Code section 1780(d) by attaching it as Exhibit 2 to this Complaint.

SECOND CAUSE OF ACTION
VIOLATION OF THE UCL (BUS. & PROF. CODE, §§ 17200, *ET SEQ.*) – UNLAWFUL BUSINESS ACTS AND PRACTICES

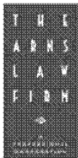
On Behalf of Classes 1, 2, 3, 4 and 5

127. Plaintiffs reallege and incorporate by reference all paragraphs above as if set forth in detail herein.

128. Business & Professions Code §§ 17200 *et seq.* prohibits acts of "unfair competition" which is defined by Business & Professions Code § 17200 as including "any unlawful, unfair or fraudulent business act or practice." Blue Shield's conduct, as described above, constitutes unlawful business acts and practices.

129. As to Class 1 (Restitution Class), Class 2 (PPO Out-of-Pocket Class), Class 3 (EPO Out-of-Pocket Class), & Class 4 (Rollover Class): Blue Shield has violated and continues to violate Business & Professions Code § 17200's prohibition against engaging in "unlawful" business acts or practices by, inter alia:

i. Violating, and continuing to violate, the CLRA, as set forth above;
ii. Violating, and continuing to violate, Business and Professions Code, §§ 17500 *et seq.*, as set forth below;



iii. Violating, and continuing to violate, the Knox-Keene Act;[6]

iv. Violating Health and Safety Code section 1360, subdivisions (a) and (b), by making statements or allowing statements to be made regarding the Blue Shield provider network available under its ACA-compliant individual and family plans for purposes of advertising or soliciting business that, when taken in the total context in which the statements were made, were untrue, misleading, or deceptive, or amounted to representations about the plans Plaintiffs purchased that did not conform to fact, or could be understood by a person not possessing special knowledge about health care coverage to confer the benefit or advantage of a singular extensive network of providers that was not in fact available to Plaintiffs. These statements or representations related to the size and extent of Blue Shield's provider network, which was or may have been significant to Plaintiffs or any potential or existing member of the plan. Thus, through this conduct, Blue Shield is "us[ing] or permit[ting] the use of any advertising or solicitation which is untrue or misleading," "us[ing] or permit[ting] the use of any verbal statement which is untrue, misleading, or deceptive[,]" and "mak[ing] any representations about coverage offered by the plan or its cost that do[] not conform to fact" in violation of Health and Safety Code section 1360, subdivisions (a) and (b).

v. Violating Health and Safety Code section 1367.26, subdivision (a), by providing written provider lists with inaccurate information to Plaintiffs and Class members and thus failing to provide members and prospective members with a list of "contracting providers, within the enrollee's or prospective enrollee's general geographic area;"

vi. Violating Health and Safety Code section 1367.26, subdivision (d), by failing to direct Plaintiffs and Class members to an accurate, functioning provider search tool on Blue Shield's website and thus failing to "satisfy the requirements of [providing a provider list] by directing the enrollee or prospective enrollee to the plan's provider listings on its

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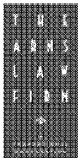
[6] Blue Shield includes in the Blue Shield EOC the following:

> This Agreement is subject to the Knox-Keene Health Care Service Plan Act, Chapter 2.2 of Division 2 of the California Health and Safety Code and Title 28 of the California Code of Regulations. Any provision required to be in this Agreement by reason of such Codes shall be binding upon Blue Shield whether or not such provision is actually included in this Agreement.



1 Internet Web site;" and

2 vii. Violating Health and Safety Code section 1373.96, by refusing to provide continuity of
3 care with a patient's physician for an acute condition, serious chronic condition,
4 pregnancy, terminal illness, a newborn child, or performance of surgery to consumers
5 who enrolled in a new health service plan during their course of treatment and thus
6 failing to provide covered services for "a period of time necessary to complete a course
7 of treatment and to arrange for a safe transfer to another provider."

8 130. As to Class 5 (Delayed Enrollment Class): Blue Shield has violated and continues
9 to violate Business & Professions Code § 17200's prohibition against engaging in "unlawful"
10 business acts or practices by:

11 i. Violating Health and Safety Code section 1367, subdivision (h)(1), by collecting
12 premium payments from Plaintiffs and Class members without initiating coverage such
13 that they cannot access benefits under their individual health service plan contracts and
14 thus failing to provide "contracts with subscribers and enrollees" that are "fair,
15 reasonable, and consistent with the objectives of [the Knox-Keene Act]."

16 131. Plaintiffs and Class members have suffered injury in fact and lost money and/or
17 property as a result of Blue Shield's and Does 1 through 100's unlawful business acts and
18 practices by, inter alia, receiving lesser coverage under their health service plan contracts, paying
19 unexpected out-of-pocket costs and inflated premiums, and/or paying out-of-pocket costs and
20 premium amounts in excess of what a Class Member would have paid if Blue Shield had
21 accurately disclosed the health service plans' provider networks.

22 132. As a result of Blue Shield's and Does 1 through 100's violations of the Business
23 and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue
24 Shield's continued violations. Plaintiffs also seek an order for disgorgement of profits derived
25 from Blue Shield's misleading and fraudulent business practices, and an order for restitution of
26 all monies paid for Blue Shield health service plans in an amount reflecting, (i) the difference in
27 the value of the health service plans with the advertised networks of providers and the value of
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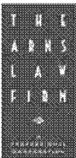


the health service plans as delivered by Blue Shield, and (ii) premium payments made by consumers for the period during which consumers were not provided ID cards.

THIRD CAUSE OF ACTION
VIOLATION OF THE UCL (BUS. & PROF. CODE, §§ 17200, *ET SEQ.*) – UNFAIR BUSINESS ACTS AND PRACTICES

On Behalf of Classes 1, 2, 3, 4 and 5

133. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.

134. As to all Classes: Blue Shield's acts and practices, as described above, constitute unfair business practices within the meaning of Business & Professions Code, §§ 17200, *et seq.*

i. Plaintiff and other members of the Class suffered a substantial injury in fact resulting in the loss of money or property by virtue of Blue Shield's conduct.

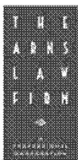
ii. Blue Shield's conduct does not benefit consumers or competition. Indeed, the injury to consumers and competition is substantial.

iii. Plaintiffs and Class members could not have reasonably avoided the injury each of them suffered.

iv. The gravity of the consequences of Blue Shield's conduct as described above outweighs any justification, motive or reason therefore, is immoral, unethical, oppressive, unscrupulous, and offends the public policy established by the State of California, which, among other things, seeks to protect the reasonable expectations of consumers concerning the nature, extent and quality of their care coverage.

135. As to all Classes: Blue Shield's conduct also violates the public policy delineated in the Knox-Keene Act. In adopting the Knox-Keene Act, it was the "intent and purpose of the Legislature to promote the delivery and the quality of health and medical care to the people of the State of California" by:

i. "Ensuring that subscribers and enrollees are educated and informed of the benefits and services available in order to enable a rational consumer choice in the marketplace." (Health & Safety Code, § 1342(b)); and



ii. "Prosecuting malefactors who make fraudulent solicitations or who use deceptive methods, misrepresentations, or practices which are inimical to the general purpose of enabling a rational choice for the consumer public." (*Id.* at (c).)

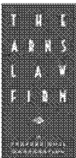
136. Blue Shield's misrepresentations, concealments, and failures to disclose run afoul of this legislatively defined public policy because they misled Plaintiffs and the Class, and will continue to deceive the consuming public in the future, about the provider network available under the advertised health service plans. This deception hindered Plaintiffs' ability to rationally evaluate and choose a health service plan.

137. As to all Classes: Blue Shield's conduct also violates multiple regulations, compliance with which is required by the Knox-Keene Act (Health & Saf. Code § 1367.03(f)(1)), and thus constitutes unfair business practices within the meaning of Business & Professions Code, §§ 17200, *et seq.* as follows:

i. By maintaining a customer service telephone system that subjects Plaintiffs and Class members to exceedingly long waiting times, regularly lasting several hours in duration, and requiring Plaintiffs and Class members to repeatedly call Blue Shield when seeking information about their plans, Blue Shield has failed to ensure that "the waiting time for an enrollee to speak by telephone with a plan customer service representative knowledgeable and competent regarding the enrollee's questions and concerns shall not exceed ten minutes" in violation of 28 CCR § 1300.67.2.2(c)(10).

ii. By misrepresenting the providers that would be in-network under Plaintiffs' and Class members' plans and consequently forcing Plaintiffs and Class members to forego care and/or seek new providers, Blue Shield has failed to "establish and maintain provider networks" that provide services to members "in a timely manner consistent with good professional practice" in violation of 28 CCR § 1300.67.2.2(c)(1).

iii. By requiring Plaintiffs and Class members to devote more than ten days to finding an in-network primary care physician with whom Plaintiffs and Class members can



make an appointment, Blue Shield is failing to "ensure that its contracted provider network has adequate capacity and availability of licensed health care providers to offer enrollees appointments that meet the [ten day] timeframe[]" for "non-urgent appointments for primary care" in violation of 28 CCR § 1300.67.2.2(c)(5)).

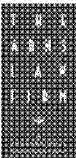
iv. By operating provider networks that violate 28 CCR § 1300.67.2.2(c)(1) and (5), as set forth above, Blue Shield is failing to "ensure [its health service plans] have sufficient numbers of contracted providers to maintain compliance with the standards established by [28 CCR § 1300.67.2.2(c)]" in violation of 28 CCR § 1300.67.2.2(c)(7).

v. By failing to provide Plaintiffs and Class Members with "a contracting or plan-operated primary care provider" "within 30 minutes or 15 miles" of their residences or workplaces, Blue Shield is failing to ensure that primary health care service facilities are located "within reasonable proximity of the business or personal residences of enrollees, and so located as to not result in unreasonable barriers to accessibility" in violation of 28 C.C.R. § 1300.67.2(a), 28 C.C.R. § 1300.67.2.1, and 20 C.C.R. § 1300.51(c)(H).

138. Blue Shield's misrepresentations therefore constitute unfair and deceptive practices in violation of Business & Professions Code, §§ 17200, *et seq.*

139. Plaintiffs and Class members have suffered injury in fact and lost money and/or property as a result of Blue Shield's and Does 1 through 100's unfair business acts and practices by, inter alia, receiving lesser coverage under their health care service plan contracts, paying unexpected out-of-pocket costs and inflated premiums, and/or paying out-of-pocket costs and premium amounts in excess of what a Class member would have paid if Blue Shield had accurately disclosed the health care service plans' provider networks.

140. As a result of Blue Shield's and Does 1 through 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue Shield's continued violations. Plaintiffs also seek an order for disgorgement of profits derived



from Blue Shield's misleading and fraudulent business practices, and an order for restitution of all monies paid for Blue Shield health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the advertised networks of providers and the value of the health service plans as delivered by Blue Shield, and (ii) premium payments made by consumers for the period during which consumers were not provided ID cards.

FOURTH CAUSE OF ACTION
VIOLATION OF THE UCL (BUS. & PROF. CODE, §§ 17200, *ET SEQ.*) – FRAUDULENT BUSINESS ACTS AND PRACTICES

On Behalf of Classes 1, 2, 3, 4 and 5

141. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.

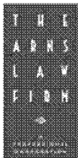
142. Blue Shield's conduct as set forth herein constitutes fraudulent business practices under Business & Professions Code, §§ 17200, *et seq.*

143. As to Class 1 (Restitution Class), Class 2 (PPO Out-of-Pocket Class), Class 3 (EPO Out-of-Pocket Class), & Class 4 (Rollover Class): As described herein:

i. Blue Shield made uniform misleading and fraudulent communications, including statements in their online and television marketing material and Evidence of Coverage documents, indicating that Plaintiffs would be given access to a singular and expansive Blue Shield provider network and/or that specific physicians would be available to them through the Blue Shield plans they had purchased or would later purchase.

ii. Said communications were made with actual knowledge of their falsity, or with reckless disregard or deliberate ignorance of whether or not they were false.

iii. Blue Shield further intentionally failed to disclose, actively concealed, and/or prevented Plaintiffs from discovering the true nature of the actual narrow provider network and the number and identity of providers who would be available to them through the uniform and deceptive communications distributed by Blue Shield. This fact was known only by Blue Shield. Plaintiffs and the Class members could not have discovered it and indeed did not know about the true nature of the available network.



iv. Blue Shield's misleading and fraudulent representations and omissions were and are likely to deceive reasonable California consumers, leading them to believe they are purchasing or have purchased a health service that offers coverage for treatment from a singular, expansive Blue Shield provider network or specific providers when, in fact, Plaintiffs' plans offer access to a significantly lesser network.

v. Plaintiffs were deceived regarding the nature of the Blue Shield provider network and the number and identity of providers who would be available to them through the uniform and deceptive communications distributed by Blue Shield.

144. As to Class 5 (Delayed Enrollment Class): As described herein:

i. Blue Shield represented to Class members that they would receive their ID cards and proof of coverage upon payment of premium.

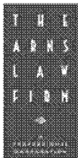
ii. Blue Shield's misleading and fraudulent representations and omissions were and are likely to deceive reasonable California consumers, leading them to believe they are purchasing or have purchased a health service that offers coverage for treatment that provides coverage upon payment of premium when, in fact, Plaintiffs' did not receive proof of coverage when promised.

iii. Plaintiffs were deceived regarding the initiation date of their coverage through Blue Shield's uniform and deceptive communications.

145. These communications regarded a material aspect of and were a substantial factor leading to the transactions between Plaintiffs and Blue Shield, including Plaintiffs' decisions to purchase and renew their subscriptions to Blue Shield's health service plans and Plaintiffs' requests to Blue Shield to cover medical treatment.

146. Blue Shield's conduct caused Plaintiffs to pay more for health coverage or receive a significantly lesser product than that for which they bargained. Absent Blue Shield's misleading and fraudulent conduct, Plaintiffs would not have accepted the terms of the transactions between Plaintiffs and Blue Shield.

147. Plaintiffs suffered concrete and identifiable economic injuries as a consequence of Blue Shield's misleading and fraudulent conduct, including but not limited to out-of-pocket expenses for medical treatment and expenses for the purchase of a health service plan that was a significantly lesser product than that for which they bargained.



148. As a result of Blue Shield's and Does 1 through 100's violations of the Business and Professions Code section 17200, Plaintiffs seek an order of this Court enjoining Blue Shield's continued violations. Plaintiffs also seek an order for disgorgement of profits derived from Blue Shield's misleading and fraudulent business practices and an order for restitution of all monies paid for Blue Shield health service plans in an amount reflecting, (i) the difference in the value of the health service plans with the advertised networks of providers and the value of the health service plans as delivered by Blue Shield, and (ii) premium payments made by consumers for the period during which consumers were not provided ID cards.

FIFTH CAUSE OF ACTION
VIOLATION OF THE FALSE ADVERTISING LAW (BUS. & PROF. CODE, §§ 17500, *ET SEQ.*)

On Behalf of Classes 1, 2, 3, and 4 and 5

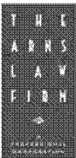
149. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.

150. Blue Shield's conduct as set forth herein constitutes false advertising under Business & Professions Code, §§ 17500, *et seq.*

151. As to Class 1 (Restitution Class), Class 2 (PPO Out-of-Pocket Class), Class 3 (EPO Out-of-Pocket Class), & Class 4 (Rollover Class): As described herein, Blue Shield made uniform false, misleading, deceptive, or fraudulent communications, including statements in their online and television marketing material and Evidence of Coverage documents, indicating that Plaintiffs would be given access to a singular and expansive Blue Shield provider network and/or that specific physicians would be available to them through the Blue Shield plans they had purchased or would later purchase.

152. At the time Blue Shield made the communications in question, Blue Shield knew or should have known that their communications regarding the nature of the Blue Shield provider network and the number and identity of providers who would be available to Plaintiffs were false, misleading, deceptive, or fraudulent.

153. Blue Shield's communications have been and continue to be likely to deceive reasonable consumers, leading them to believe they are purchasing or have purchased a health care service plan that offers coverage for treatment from a singular expansive Blue Shield



provider network or specific providers when, in fact, Plaintiffs' plans offer access to a significantly lesser network.

154. Blue Shield's communications regarded a material aspect of and a substantial factor leading to the transactions between Plaintiffs and Blue Shield, including Plaintiffs' decisions to purchase and renew their subscriptions to Blue Shield's health service plans and Plaintiffs' requests to Blue Shield to cover medical treatment.

155. Plaintiffs were induced to alter their position to their detriments by Blue Shield's false, misleading, deceptive, or fraudulent communications regarding the nature of the Blue Shield provider network and the number and identity of providers who would be available to them.

156. Blue Shield's conduct caused Plaintiffs to pay more for health coverage or receive a significantly lesser product than that for which they bargained. Absent Blue Shield's misleading and fraudulent conduct, Plaintiffs would not have accepted the terms of the transactions between Plaintiffs and Blue Shield.

157. Plaintiffs suffered concrete and identifiable economic injuries as a consequence of Blue Shield's misleading and fraudulent conduct, including but not limited to out-of-pocket expenses for medical treatment and expenses for the purchase of a health service plan that was a significantly lesser product than that for which they bargained.

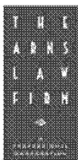
158. As a result of Blue Shield's and Does 1 through 100's violations of the Business and Professions Code section 17500, Plaintiffs seek an order of this Court enjoining Blue Shield's continued violations. Plaintiffs also seek an order for restitution of all monies paid for Blue Shield health service plans in an amount reflecting the difference in the value of the health service plans with the advertised networks of providers and the value of the health service plans as delivered by Blue Shield.

SIXTH CAUSE OF ACTION
BREACH OF CONTRACT

On Behalf of Classes 2, 3, and 5

159. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.

160. Plaintiffs and the Class members entered into contracts with Blue Shield by



purchasing and renewing their health service plans.

161. The relevant terms of the contract between Plaintiffs and each Class member, on the one hand, and Blue Shield, on the other, are materially identical at all relevant times. These terms detailed the offer, acceptance and consideration necessary to form a contract for Blue Shield to pay for the medical needs of its members in exchange for the members' payment of premiums.

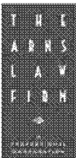
162. Plaintiffs and each Class member accepted Blue Shield's offer to provide health care service plans by paying Blue Shield consideration in the form of premiums. In exchange, Blue Shield promised to pay for members' medical services according to the terms established in the contracts.

163. As to Class 2 (PPO Out-of-Pocket Class) & Class 3 (EPO Out-of-Pocket Class): The terms of the contracts required Blue Shield to reimburse in-network providers at the amount or percentage specified in the members' particular plans. Blue Shield, however, stated on its website that certain providers were in-network, and then denied members' claims for those providers as being out-of-network. Blue Shield's failure to fully reimburse claims for providers that were listed on Blue Shield's website as being in-network constitutes breaches of contract.

164. As to Class 2 (PPO Out-of-Pocket Class) & Class 3 (EPO Out-of-Pocket Class): By providing to Plaintiffs and the Class members a network of providers that is lesser than the Blue Shield of California PPO network of providers that Blue Shield promised, as well as by denying coverage, either at the in-network level of benefits or all together, for medical treatment Plaintiffs sought and received while subscribed to Blue Shield health service plans from providers Plaintiffs reasonably believed were in-network under their plans, Blue Shield has uniformly breached the terms and provisions of the health service plan contracts entered into with Plaintiffs and members of the Class.

165. As to Class 5 (Delayed Enrollment Class): Blue Shield breached the contract by failing to provide Plaintiffs and Class members with ID cards and proof of enrollment sufficient for them to obtain covered medical services under their health service plan contracts, leading them to have to pay out-of-pocket for such services, or to forego or delay obtaining those services.

166. As a direct result of Blue Shield's conduct and breach of contractual obligations,



Plaintiffs and members of the Class suffered damages under the individual plan contracts in an amount to be determined according to proof at trial.

SEVENTH CAUSE OF ACTION
BREACH OF THE IMPLIED COVENANT OF GOOD FAITH AND FAIR DEALING
On Behalf of Classes 2, 3, and 5

167. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.

168. The relevant terms of the contract between Plaintiffs and Class members, on the one hand, and Blue Shield on the other, were materially identical at all relevant times. These terms detailed the offer, acceptance and consideration necessary for the extension of the health insurance policies, described above.

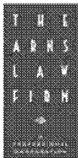
169. The contract contains an implied covenant of good faith and fair dealing prohibiting Blue Shield from doing anything that would deprive Plaintiffs and members of the Class of the benefits of the contract, and imposing a duty on Blue Shield to do everything that the contract presupposes it will do to accomplish its purpose.

170. As to Class 2 (PPO Out-of-Pocket Class) & Class 3 (EPO Out-of-Pocket Class):

i. Blue Shield's conduct, as alleged herein, breached the implied covenant of good faith and fair dealing. The terms of the contracts required Blue Shield to reimburse in-network providers at the amount or percentage specified in the members' particular plans. Blue Shield, however, stated on its website that certain providers were in-network, and then denied members' claims for those providers as being out-of-network.

ii. By not providing the network of providers promised under the contract and by refusing to provide coverage, either at the in-network level of benefits or all together, for Plaintiffs' medical treatment, Blue Shield failed to pay benefits due under Plaintiffs' health service plans.

iii. Blue Shield unreasonably and without proper cause acted or failed to act in a manner that deprived Plaintiffs of the purported benefits of their health service plans by providing to Plaintiffs and Class members availability of a network of providers that is significantly lesser than the Blue Shield of California PPO network of providers that



was promised, as well as by denying coverage, either at the in-network level of benefits or all together, for medical treatment Plaintiffs sought and received while covered under Blue Shield health service plans from providers Plaintiffs reasonably believed were in-network, thereby requiring Plaintiffs to suffer out-of-pocket expenses.

iv. Blue Shield acted unreasonably or without proper cause by, inter alia, misrepresenting to Plaintiffs relevant facts or health service plan provisions relating to coverage issues, namely the extent of the provider network available to them.

171. As to Class 5 (Delayed Enrollment Class): Blue Shield also breached the covenant of good faith and fair dealing by failing to provide Plaintiffs and Class members with ID cards and proof of enrollment sufficient for them to obtain covered medical services under their health service plan contracts, leading them to have to pay out-of-pocket for such services, or to forego or delay obtaining those services.

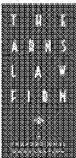
172. As a proximate result of the aforementioned unreasonable and bad faith conduct of Blue Shield, Plaintiffs and member of the Class have suffered, and will continue to suffer in the future, damages under the health service plans, plus interest, and other economic and consequential damages, in an amount to be proven at trial. Blue Shield's actions or failures to act were a substantial factor in causing Plaintiffs to suffer these harms.

173. Blue Shield was notified of the loss. Blue Shield's conduct described herein was undertaken by Blue Shield's officers or managing agents who were responsible for claims supervision. The previously described conduct of said managing agents and individuals was therefore undertaken on behalf of Blue Shield. Blue Shield further had advance knowledge of the actions and conduct of said individuals whose actions and conduct were ratified, authorized, and approved by managing agents whose precise identities are unknown to Plaintiffs at this time and are therefore identified and designated.

EIGHTH CAUSE OF ACTION
DECLARATORY RELIEF

On Behalf of Classes 2 and 3

174. Plaintiffs reallege and incorporate the above allegations by reference as if set forth fully herein.



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175. California Code of Civil Procedure section 1060 provides that any person "interested under . . . a contract . . . may, in cases of actual controversy relating to the legal rights and duties of respective parties" bring an action in Superior Court for a declaration of his or her rights and "the court may make a binding declaration of these rights or duties, whether or not further relief is or could be claimed at the time."

176. As to Class 2 (PPO Out-of-Pocket Class) & Class 3 (EPO Out-of-Pocket Class):

i. An actual controversy has arisen between Plaintiffs and the Class members, on the one hand, and Blue Shield and Does 1 through 100 on the other, as to their respective rights and obligations under the individual health care service plan contracts between them. Specifically, Plaintiffs and the Class contend that Blue Shield's misrepresentation of provider networks, concealment of and failures to disclose the existence of significant differences between the narrow Blue Shield provider network that would be available to them through their newly issued ACA-compliant health service plans and the traditional, large Blue Shield of California PPO network, misrepresentations that specific physicians and hospitals were in-network under Plaintiffs' and the Class's health service plans, and Blue Shield's other misrepresentations and omissions as more fully described herein, are prohibited by California law. Blue Shield contends that their conduct was proper.

177. Plaintiffs seek a declaration as to the respective rights and obligations of the parties.

PRAYER FOR RELIEF

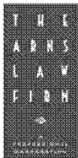
WHEREFORE, Plaintiffs, pray for judgment against Blue Shield as follows:

A. An order certifying this case as a class action and appointing Plaintiffs Harrington, Talon, Sullivan, Turner, Daum, Yerkes, Harvey, the McCarthys, Greer, Mehner, Carlson, Weiss, Scarpo, and Asher and their counsel to represent the Class;

B. For actual and compensatory damages according to proof pursuant to the Civil Code, Business & Professions Code, and all other applicable laws and regulations;

C. For restitution and disgorgement to the extent permitted by applicable law;

D. For an order enjoining Defendants from continuing to engage in the conduct described herein;



E. For civil and statutory penalties available under applicable law;

F. For pre-judgment and post-judgment interest;

G. For punitive damages;

H. For an award of attorneys' fees, costs and expenses as authorized by applicable law;

I. For such other and further relief as this Court may deem just and proper; and

J. For trial by jury on all causes of action so triable.

Dated: August 7, 2015

THE ARNS LAW FIRM

By: /s/ Robert S. Arns

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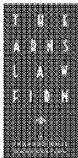

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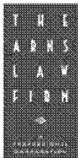

CERTIFICATE OF SERVICE

I, the undersigned, declare as follows:

I am a citizen of the United States, over the age of 18 years and not a party to, nor interested in, the above-entitled action. I am an employee of The Arns Law Firm, A Professional Corporation, and my business address is 515 Folsom Street, 3rd Floor, San Francisco, CA 94105

On August 13, 2015, I served the following: **CONSOLIDATED CLASS ACTION COMPLAINT FOR DAMAGES [C.C.P. § 382] WITH EXHIBITS AND DEMAND FOR JURY TRIAL**

on all interested parties in the above cause, by **ELECTRONIC SERVICE** by electronically serving the document described above via LexisNexis File & ServeXpress, on the recipients designated on the Transaction Receipt lcated on the LexisNexis File & ServeExpress website (www.fileandserveexpress.com).

The parties were served as follows:
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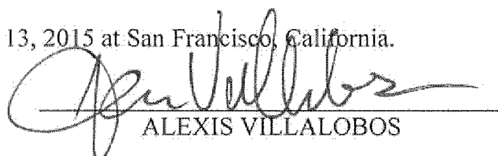
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct:

Executed on August 13, 2015 at San Francisco, California.



ALEXIS VILLALOBOS